Court, U.S.
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No.

In the Supreme Court of the United States

JOSE MONTEMAYOR, COMMISSIONER OF THE TEXAS DEPARTMENT OF INSURANCE; JOHN CORNYN, ATTORNEY GENERAL OF TEXAS,
Petitioners,

v.

CORPORATE HEALTH INSURANCE, INC.; AETNA HEALTH PLANS OF TEXAS, INC.; AETNA HEALTH PLANS OF NORTH TEXAS, INC.; AETNA LIFE INSURANCE COMPANY,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Is ERISA § 502(a) an exclusive remedy provision that preempts state insurance law remedies that otherwise would be saved by the savings clause?

2. Do ERISA and FEHBA preempt state laws providing independent physician review of managed care organizations' medical necessity decisions?

LIST OF PARTIES TO THE PROCEEDING

The Petitioners are Jose Montemayor, Commissioner of the Texas Department of Insurance, and John Cornyn, Attorney General of the State of Texas. The Respondents are Corporate Health Insurance, Inc., Aetna Health Plans of Texas, Inc. (now known as Aetna U.S. Healthcare, Inc.), Aetna Health Plans of North Texas, Inc. (now known as Aetna U.S. Healthcare of North Texas, Inc.), and Aetna Life Insurance Company.

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PETITION FOR WRIT OF CERTIORARI

The Fifth and Seventh Circuits conflict over whether *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987), and ERISA §502(a) require preemption of state insurance laws that provide for independent review of medical necessity determinations made by managed care organizations. The conflict among the circuits over the preemptive force of §502(a) is not limited to these two circuits. The Fifth Circuit and other circuit courts read *Pilot Life* to hold that §502(a) is an exclusive remedy provision that preempts state insurance law remedies. The Second and Third Circuits hold that remedial state insurance laws can be enforced because they are expressly saved from preemption by ERISA §514(b)(2)(A), the "savings clause," and do not conflict with §502(a). The very purpose of Congress in enacting the savings clause is frustrated by the Fifth Circuit's holding that states cannot enforce the remedies provided in their insurance laws.

Not only is the states' right to enforce their insurance laws at issue in this case, the states' right to protect their citizens' health is at stake. The Texas independent review law reviews decisions that affect the health of citizens. Medical care likely will not be provided when a managed care organization determines that the care, despite being recommended by an attending physician, is not medically necessary. Texas exercised its traditional role to protect the health of its citizens by enacting an independent review law. No basis exists for the Fifth Circuit to conclude that Congress intended for ERISA §514(a) and FEHBA to preempt Texas' historical state right to regulate health care.

OPINIONS BELOW

The opinion of the court of appeals is *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, 215 F.3d 526 (5th Cir. 2000). A published opinion denying panel rehearing and rehearing *en banc* is reported at 220 F.3d 641 (5th Cir. 2000). The opinion of the United States District Court for the Southern District of Texas is reported at 12 F. Supp.2d 597 (S.D. Tex. 1998).

JURISDICTIONAL STATEMENT

The court of appeals entered its judgment on June 20, 2000. The Texas defendants timely filed a petition for panel rehearing and petition for rehearing *en banc* on July 3, 2000. Both petitions were denied on July 27, 2000. This Court has jurisdiction under 28 U.S.C. § 1254(1).

FEDERAL STATUTES INVOLVED

The federal statutes involved in this case are the Employee Retirement Income Security Act of 1974 ("ERISA") and the Federal Employees Health Benefits Act ("FEHBA").

ERISA §502(a)(1)(B), 29 U.S.C. § 1132(a) (1)(B) provides:

> (a) Persons empowered to bring a civil action
> A civil action may be brought —
> (1) by a participant or beneficiary—
>
> . . .

> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

ERISA §514(a), 29 U.S.C. § 1144(a), provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section1003(b) of this title.

ERISA §514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), provides:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

FEHBA, 5 U.S.C. § 8901(m)(1), provides:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supercede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

STATEMENT OF THE CASE

In 1997, Texas enacted Senate Bill 386 (SB 386),[1] amending the Texas Insurance Code to create an Independent Review Organization (IRO process).[2] The IRO process provides for independent, external physician-review of adverse determinations of medical necessity made by managed care organizations (MCOs).[3] An adverse determination is a decision that medical care an attending physician recommends be provided or continued is not medically necessary.[4] These medical necessity decisions directly affect the health of the

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[1] Act of May 22, 1997, 75th Leg., R.S., ch. 163, § 1, 1997 Tex. Gen. Laws 317.

[2] SB 386 also afforded Texans a number of other patient protections, including the right to sue managed care organizations that fail to meet an ordinary care standard for health care treatment decisions. The Fifth Circuit held these other protections were not preempted.

[3] MCOs include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and insurers and other entities involved in providing or arranging for managed health care.

[4] A decision that "health care services furnished or proposed to be furnished to a patient are not medically necessary" is defined as an "adverse determination" in the HMO Act and the Utilization Review Act (URA). TEX. INS. CODE arts. 20A.12A(a)(1), 21.58A, §2(3). The HMO Act provides that reviews of adverse determinations be made in accordance with the URA. *Id.* art. 20A.12A(c). Pursuant to the URA, adverse determinations for "health care services furnished" are subject to internal review by the MCO. *Id.* art. 21.58A, §11(a). Adverse determinations for health care services "proposed to be furnished" are subject to the IRO process and include concurrent and prospective requests for treatment, defined in the URA as "utilization review," but do not include requests for clarification of coverage. *Id.* art. 21.58A, §2(20).

insureds and enrollees of managed care plans because of the likelihood that denied care will not be obtained.

Aetna[5] sued the Texas Department of Insurance,[6] the Texas Commissioner of Insurance, and the Attorney General of Texas[7] alleging that ERISA and FEHBA preempted SB 386. [B-16.] The Fifth Circuit upheld the majority of the provisions, but held that the IRO provisions were preempted by ERISA §502(a)(1)(b) and FEHBA. The Fifth Circuit then severed the preempted provisions from the Act. [A-18.][8]

The Fifth Circuit rejected Texas' argument that medical necessity determinations are "mixed eligibility decisions" as defined by this Court in *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000). [D-2-3.] Instead, it held that the IRO provisions "relate to" ERISA under ERISA §514(a). [A-11-12.] The Fifth Circuit applied *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. 358 (1999), to find the IRO process was a state insurance law, but nonetheless held that ERISA's insurance savings clause did not apply. [A-13-16.]

The Fifth Circuit interpreted this Court's decision in *Pilot Life* as requiring preemption of the IRO process because

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[5] Respondents collectively will be referred to as "Aetna."

[6] The district court dismissed the Texas Department of Insurance as a party pursuant to the Eleventh Amendment. [B-11.] Appendix citations appear in brackets to the page number in the Appendix; e.g., Appendix B at page 11 is [B-11.].

[7] Petitioners collectively will be referred to as "Texas" or "the State."

[8] The Texas Insurance Code provisions held preempted by the Fifth Circuit are reprinted in Appendix E.

the IRO provisions create a "quasi-administrative procedure" for review of benefit denials that conflicts with ERISA §502(a)(1)(b). [A-15.] Essentially, the Fifth Circuit held that ERISA §502(a)(1)(b) trumps the savings clause by preempting the field of state insurance law remedies. [A-15-16.] Additionally, the court of appeals held the IRO provisions were preempted by FEHBA. [A-17.] This petition for writ of certiorari seeks review of those conclusions.

REASONS FOR GRANTING THE PETITION

I. There is Conflict Among the Circuits as to the Preemptive Effect of ERISA §502(a).

The Fifth Circuit's interpretation of ERISA §502(a) directly conflicts with the Seventh Circuit's opinion in *Moran v. Rush Prudential HMO, Inc.*, 2000 WL 1551659, *12 (7th Cir. Oct. 19, 2000); *see id.* at *12 n.7 (Posner, J., dissenting from denial of *reh'g en banc*) (noting the "square conflict" between the Fifth and Seventh Circuits). In recent years, this Court has been called upon to resolve conflicting and incorrect circuit court interpretations of its ERISA preemption decisions. This case presents another such occasion.

In *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995), the Court corrected the expansive and literalistic interpretation of ERISA's preemption provision, §514(a), that circuits erroneously thought *Shaw v. Delta Air Lines, Inc.*, 463 U.S.

85 (1983), required.[9] Next, in *Ward*, the Court clarified that in determining whether a state law was an insurance law saved from preemption under ERISA §514(b)(2)(A), not all of the McCarran-Ferguson Act criteria needed to be present. This resolved conflicting circuit court interpretations of *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), and *Pilot Life*. *See Ward*, 526 U.S. at 373. Now, Texas petitions the Court to resolve conflicting interpretations of ERISA §502(a)'s effect on the savings clause. In particular, at issue is the Fifth Circuit's erroneous interpretation that *Pilot Life* requires preemption of Texas' IRO process.

A. The Seventh Circuit's Decision in *Moran* Directly Conflicts with the Fifth Circuit's Decision in *Corporate Health*.

In *Moran*, the Seventh Circuit held that Illinois' independent review law was not preempted by ERISA. That decision directly conflicts with the Fifth Circuit's decision. The Illinois law, like Texas', requires independent physician review of a MCO's decision that the treatment recommended by an attending physician is not medically necessary. *See* 2000 WL 1551659 at *3.[10] The plaintiff, Ms. Moran, suffered from

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[9] *See De Buono v. NYSA-ILA Med. & Clinical Serv. Fund*, 520 U.S. 806, 812-13 (1997); *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 325 (1997).

[10] The Texas and Illinois statutes are not mirror images, however. *Moran* concerned retrospective review for reimbursement for medical treatment provided. The Texas IRO process concerns prospective and concurrent requests that affect whether medical treatment will be

nerve compression syndrome and her doctors recommended microneurolysis surgery. *Id.* at *1-2. Her HMO, Rush, reviewed the request internally and determined the surgery was not medically necessary. *Id.* at *2. Nevertheless, Ms. Moran underwent the surgery and then sought reimbursement from Rush. *Id.* at *3. After being ordered by a state court to submit to an independent physician review, in which the surgery was found to be medically necessary, Rush again denied Ms. Moran's insurance claim. *Id.* at *4. She then asked the state court to enforce the independent review decision. *Id.* Rush removed the case to federal court claiming ERISA §502(a) completely preempted her reimbursement claim. *Id.*

The Seventh Circuit held that ERISA's savings clause applied to Illinois' independent physician review statute. *Id.* at *9. The Illinois statute, like Texas' statute, was held to regulate insurance under a common sense understanding and to meet at least two of the McCarran-Ferguson Act factors. *Id.* The Seventh Circuit held the statute was saved from ERISA §514(a) "relates to" preemption under this Court's decision in *Ward*. *Id.*

The Seventh Circuit, unlike the Fifth, held that a state independent review law is not preempted by §502(a). A claim to enforce the independent review decision "cannot be characterized as creating an alternative remedy scheme that conflicts with sec. 502(a)," because they are "not tantamount to the relief offered under sec. 502(a)(1)(B)." *Id.* at *11.

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provided or continued. *See supra* note 4; *see also infra* note 18.

Rather, independent review "simply adds to the contract, by operation of law, an additional dispute resolving mechanism." *Id.* The Seventh Circuit recharacterized Ms. Moran's claim as a benefits claim under ERISA §502(a) and distinguished *Pilot Life*. *Id.* at *12 (citing *Ward*, 526 U.S. at 375-76). By recharacterizing the claim, the court determined that *Pilot Life* did not require preemption. *Id.* Thus, the Seventh Circuit held the Illinois independent review law provided the rule of decision in Ms. Moran's ERISA §502(a) claim for reimbursement. *Id.* at *13.

The Seventh Circuit had previously ruled that state insurance laws can be enforced in a §502(a) proceeding. *Plumb v. Fluid Pump Serv.*, 124 F.3d 849, 862 (7th Cir. 1997) (holding an Illinois insurance statute becomes part of the substantive content of a plan, but does not conflict with ERISA's substantive scheme because an action to enforce the policy as modified by the state insurance law can only be brought under ERISA §502(a)). The Sixth and Eighth Circuits also hold that state insurance laws become part of the ERISA plan, but may only be enforced in a §502(a) suit. *See Ruble v. UNUM Life Ins. Co.*, 913 F.2d 295, 297 (6th Cir. 1990) (holding saved insurance laws modify the terms of the insurance policy, but "any action brought by a beneficiary to enforce the policy as so modified could only be brought under §502(a) of ERISA."); *Donatelli v. Home Ins. Co.*, 992 F.2d 763, 765 (8th Cir. 1993) (holding that a saved state insurance law "will govern the interpretation of the [insurance] policy, but that does not effect the preemption of state law remedies

by §1132.").[11] The Fifth Circuit is thus in conflict with the Sixth, Seventh and Eighth Circuits.

Judges Posner, Coffey, Easterbrook, and Wood dissented from the denial of rehearing *en banc* in *Moran*. 2000 WL 1551659 at *12 n.7. They noted that the opinion "creates a square conflict with another circuit, is probably unsound, and will affect an enormous number of cases." *Id.* While Texas agrees that *Moran* presents a square conflict with *Corporate Health* and that both holdings will affect an enormous number of cases, the *Moran* analysis was not unsound.

In his dissent, Judge Posner reasoned that:

> If the statute merely regulates insurance and therefore is not preempted, how can it be part of an ERISA plan and enforceable in federal court? If, on the other hand, the requirement imposed by the statute is and must be incorporated into the plan, then Illinois has done more than merely regulate the contents of an insurance policy. It has regulated the contents of an ERISA plan–which means that it is preempted.

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[11] *But see In re Life Ins. Co. of N. Am.*, 857 F.2d 1190, 1194 (8th Cir. 1988) ("The Court in *Pilot Life* could not have stated with any greater clarity that the remedies under ERISA are exclusive, and no state law purporting to supply additional remedies will escape the preemptive effect of §1144(a) as laws 'which regulate insurance' under §1144(b)(2)(A).").

Id. at *12 n.7. This reasoning, however, misses the point of the savings clause entirely. States can regulate the contents of ERISA plans indirectly through direct regulation of the contents of insurance policies. *FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990) ("[I]f a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts.").[12] The Court reaffirmed this principle in *Ward*. 526 U.S. at 377. "We have repeatedly held that state laws mandating insurance contract terms are saved from preemption." *Ward*, 526 U.S. at 375.

B. *Moran* Is Consistent with this Court's Decision in *Ward*; *Corporate Health* Is Not.

Under this Court's decision in *Ward*, the Texas IRO process, as well as the Illinois independent review law, are saved from preemption in a §502(a) enforcement action. The IRO process creates a procedural right that an ERISA beneficiary can assert in a §502(a) enforcement action. This procedural right confers the state rule of decision to be used in a §502(a) proceeding. This is no different than the state insurance law this Court held was saved from preemption in *Ward*.

In *Ward*, the issue was whether a state rule of decision, the notice-prejudice rule, was applicable to an ERISA plan. *Id.*

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[12] The analysis also fails because an insurer or employer cannot usurp state regulatory authority by clever draftsmanship of a policy or plan. An insurer cannot "displace any state regulation simply by inserting a contrary term in plan documents." *Ward*, 526 U.S. at 376.

at 364. The ERISA plan provided disability coverage through an insurer and contained a notice provision that if not met barred benefits. *Id.* California law provides that such a notice provision cannot be invoked absent a showing of prejudice. *Id.* at 366-67. The Court held the rule was a law regulating insurance. *Id.* at 372.

UNUM contended that §502(a) preempted an action for benefits brought under the state law. *Id.* at 375. Because benefits were sought under §502(a) in that case, the Court did not need to decide if "§502(a) provides the sole launching ground for an ERISA enforcement action." *Id.* at 377. The Court ruled the notice-prejudice rule did not conflict with §502(a) even though the effect of the rule was to bind the plan to pay benefits, because "[t]he notice-prejudice rule supplied the relevant rule of decision for this §502 suit." *Id.*

Additionally, UNUM argued "that the notice prejudice rule conflicted with §503 of ERISA." *Id.* The Court rejected this argument because "[b]y allowing a larger period to file than the minimum filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulation." *Id.* If the notice-prejudice rule did not conflict with ERISA because it added to a procedural provision of ERISA, then Texas' IRO process, which complements ERISA's remedies, likewise is not in conflict.

The savings clause incorporates state law into the plan providing benefits, i.e., the mandated benefit law in *Metropolitan Life* and the notice-prejudice rule in *Ward.* "Here, the [IRO] provisions create a procedural right of the

insured against the entity." [A-14.] The IRO provisions are incorporated into ERISA plans and supply the relevant rule of decision in a §502(a) suit. Thus, to the extent the IRO process is relied upon in a §502(a) enforcement action, under *Ward*, it is not preempted by ERISA. The Seventh Circuit properly applied *Ward*, but the Fifth Circuit did not.

C. The Fifth and Other Circuits Misinterpret *Pilot Life*.

The Fifth Circuit interprets *Pilot Life* as holding that ERISA §502(a) precludes operation of the savings clause when state insurance law remedies are at issue. [A-15-16.] The Ninth and Eleventh Circuits concur. *See Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988); *Anschultz v. Connecticut Gen. Life Ins. Co.*, 850 F.2d 1467, 1469 (11th Cir. 1988). The Sixth, Seventh, and Eighth Circuits view *Pilot Life* as allowing for state insurance remedies so long as they are enforced in an ERISA §502(a) proceeding. *See supra* pp. 9-10. Texas submits that neither interpretation is correct, because *Pilot Life* did not involve a law regulating insurance within the meaning of the savings clause and is not controlling.

The plaintiff in *Pilot Life* sought extra-contractual damages for emotional distress and punitive and exemplary damages under Mississippi law for failure to timely pay a claim. 481 U.S. at 43. This Court reasoned that the claims based on Mississippi's law of bad faith "are firmly planted in the general principles of Mississippi tort and contract law" and that "[a]ny breach of contract and not merely breach of an

insurance contract, may lead to liability for punitive damages under Mississippi law." *Id.* at 50. Thus, the law could not be considered an insurance law subject to ERISA's savings clause.

Although this finding was sufficient for resolution of the matter, the Court went on to discuss whether §502(a) was an exclusive remedy provision. Based on an argument advanced by the Solicitor General,[13] the Court reasoned that Congress did not intend to provide remedies to ERISA beneficiaries in addition to those specified in §502(a). *Pilot Life*, 481 U.S. at 52. That analysis, however, does not resolve whether state insurance law remedies can be saved from preemption, because the law at issue in *Pilot Life* was not an insurance law.

This Court determined in *Ward* that it did not need to revisit *Pilot Life*, but nevertheless took the opportunity to clarify that *Pilot Life* was not a decision interpreting the savings clause. *Ward*, 526 U.S. at 376 n.7. Rather, *Pilot Life* "concerned Mississippi common law creating a cause of action

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[13] In *Pilot Life*, the Solicitor General argued that because §502(a) was patterned after §301 of the Labor-Management Relations Act of 1947, §502(a) should be considered an exclusive remedy provision. In *Ward*, the Solicitor General qualified its earlier argument, noting that the law at issue in *Pilot Life* was not a law regulating insurance. *Ward*, 526 U.S. at 376 n.7. The Solicitor General also explained that §301 did not have a savings clause, and thus could not be considered controlling in regards to saved state insurance laws. *See* Brief for the United States at *25, *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999) (No. 97-1868), 1998 WL 839957.

for bad faith breach of contract, *law not specifically directed to the insurance industry and therefore not saved from preemption*." *Id.* (emphasis added). The Fifth Circuit's conclusion that *Pilot Life* is dispositive in this case is thus erroneous.

D. The Fifth Circuit's Decision Conflicts with Decisions of the Second and Third Circuits.

The Second and Third Circuits do not view *Pilot Life* as an obstacle either to saving state insurance law remedies from preemption or to enforcement of those remedies in a state proceeding. *See Franklin H. Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144, 151 (2nd Cir. 1995) (*Williams Trust*); *Pas v. Travelers Ins. Co.*, 7 F.3d 349, 356 (3rd Cir. 1993). The Second Circuit distinguished conflicting circuit court rulings by noting that those decisions "involve statutes that, while impacting upon the insurance industry, are based upon contract and tort principles." *Williams Trust*, 50 F.3d at 150. The Third Circuit simply said that to the extent other circuits reach "a result contrary to the one we reach here, our preference is understandably for our own result." *Pas*, 7 F.3d at 357.

The Second Circuit in *Williams Trust* gave effect to the plain meaning of the savings clause. 50 F.3d at 151. The savings clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). ERISA §502(a) is part of the subchapter referred to in the savings clause. Therefore, nothing in

§502(a) can be construed to prevent application of a state insurance law remedy.[14] The Second Circuit applied this plain meaning to save the state insurance law at issue in *Williams Trust*, holding "[i]t would be quixotic to rule that a claim under a state statute that is saved from preemption . . . may nonetheless be enforced only via ERISA provisions and remedies." *Id.*

The Fifth Circuit's and other courts' holdings that *Pilot Life* prevents insurance law remedies from being saved rewrite the savings clause. Now, state insurance laws that have the effect of ensuring that a promised benefit is provided cannot be saved. Insurance regulation serves one basic purpose—to make sure promised benefits are provided when needed. This is done through regulation of solvency and regulation of claims practices to insure that claims can and will be paid. *See Metropolitan Life*, 471 U.S. at 728 n.2. To say, as the Fifth Circuit has, that any state insurance law that has the effect of requiring the payment of a claim cannot be saved from preemption, is to defeat a fundamental purpose of state insurance law—law Congress expressly saved from preemption. *See id.* at 746-47.

The effect of an IRO decision—that a benefit is received because it is found to be medically necessary—is similar to the

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[14] The Solicitor General argued the plain meaning of the savings clause should be applied in *Ward*. "[T]he insurance savings clause on its face, saves state laws conferring causes of action or affecting remedies that regulate insurance, just as it does state mandated benefits laws and other prescriptive measures that do so." Brief for United States, 1998 WL 839957 at *23.

effect of the law held saved from preemption in *Metropolitan Life*. There, the state law required the provision of mental health treatment. Here, the state law requires the provision or continuation of medical treatment if the IRO agrees with the attending physician. The result is the same under both laws. In one, a substantive right to mental health care is provided through inclusion of a mandated mental-health-care benefit in insurance policies. In the other, a procedural right to obtain medical care is provided through inclusion of a right to appeal an adverse determination in insurance contracts and certificates of coverage.[15]

The Third Circuit rejects the analysis that §502(a) precludes all state insurance law remedies. *Pas*, 7 F.3d at 356. *Pas* concerned whether an ERISA beneficiary could assert a claim in state court that termination of her insurance coverage violated New Jersey insurance law by discriminating against an insured with a disability. *Id.* at 351. Travelers sought mandamus when the district court remanded the state-law claim, arguing that ERISA preempted the state claim because "plaintiff's cause of action directly conflicts with the federal cause of action under ERISA §502(a)(1)(B)." *Id.* at 356. Aetna advanced precisely the same argument in this case, and the Fifth Circuit accepted it. The Third Circuit, in contrast, rejected the argument because it "misapprehends the requirements for conflict preemption." *Id.*

The Third Circuit applied conflict preemption analysis based on *Ingersoll-Rand Company v. McClendon*, 498 U.S.

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[15] TEX. INS. CODE art. 20A.09(e)(4).

133 (1990). There, this Court held that "if a statute is not expressly preempted by ERISA, it is nevertheless preempted if 'it conflicts directly with an ERISA cause of action.'" *Pas*, at 356 (citing *Ingersoll-Rand*, 498 U.S. at 142-45). The Third Circuit reasoned that ERISA did not provide a cause of action equivalent to the New Jersey insurance law and that it could not reasonably be contended "that any provision of ERISA expressly guarantees this same right." *Id.* Accordingly, the Third Circuit concluded "that a necessary requirement for conflict preemption is missing here." *Id.*

Likewise, ERISA provides no remedy comparable to Texas' IRO process. ERISA has no provision for review by an independent physician of an MCO's decision to deny medical care recommended by an attending physician. Thus, under the Third Circuit's ERISA conflict preemption analysis, the IRO provisions would be saved and enforceable in a state proceeding. This result is consistent with this Court's explanation of conflict preemption as applied to the savings clause.

ERISA "leaves room for complementary or dual federal and state regulation." *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 100 (1993). Conflict preemption of state insurance law remedies occurs when the state law "cannot be harmonized or accommodated" with the federal law. *Id.* The fundamental purpose of ERISA is to protect ERISA beneficiaries and ensure that promised benefits are provided when needed. 29 U.S.C. § 1001. That is precisely what the IRO process and ERISA §502(a) are designed to do. ERISA, however, does not provide for an

independent review of medical necessity decisions. The IRO process thus complements the remedy provided in §502(a) and can be harmonized with ERISA. Accordingly, a necessary element for conflict preemption is missing here.

If the Fifth Circuit correctly held that any insurance law that binds a plan to pay a benefit is nevertheless preempted, then the savings clause would save nothing. This Court touched upon this erroneous interpretation of *Pilot Life* in *Ward*, but found that "whatever the merits of [this] view of §502(a)'s preemptive force, the issue [was] not implicated." *Ward*, 526 U.S. at 376. The merits of this view of §502(a) are squarely at issue in this case. Under the Second Circuit's plain meaning analysis and the Third Circuit's conflicts preemption analysis, state insurance law remedies are saved from ERISA preemption and can be enforced in state court proceedings. The Court should grant the petition for certiorari to resolve the conflict between the circuits and answer the two questions left unresolved after *Ward*. What is the preemptive force of §502(a)? Is §502(a) the sole launching ground for an ERISA enforcement action?

II. The Fifth Circuit's "Relates to" Analysis Conflicts with this Court's Decision in *Pegram*.

The Fifth Circuit's decision conflicts with this Court's analysis in *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000). In *Pegram*, this Court discussed the mixed nature of medical necessity decisions. 120 S. Ct. at 2154. If a MCO or plan couches coverage in terms of medical necessity, then when medical treatment is determined to be medically necessary,

that implicates a MCO's or a plan's obligation to see that the treatment is provided. This Court held that medical necessity decisions do not involve an ERISA fiduciary duty, in part because they are medical in nature and states are free to regulate those decisions through their medical malpractice laws. *Id.* at 2155. This analysis is equally applicable to the IRO process. And the Fifth Circuit should have held that states are free to regulate medical necessity decisions through independent review laws.

A. The Texas IRO Process Is Health Care Regulation.

Independent reviews can address three general types of MCO decisions. First, independent review addresses treatment that is actually provided. In such a case, there is no doubt that treatment will be provided. There is no dispute that the patient's medical condition necessitates treatment and that various treatment options are covered under the plan. The only question is what treatment will be provided. These decisions can be termed pure treatment decisions and if the MCO and attending physician provide the wrong treatment, then they can be held liable for malpractice.

In connection with SB 386's liability provisions, an independent review for pure treatment decisions is provided. Use of the independent review is a prerequisite for filing a liability action, if the MCO chooses to comply with Texas'

utilization review requirements.[16] The Fifth Circuit held this independent review was not preempted because it was voluntary. [A-12.]

Second, at the other end of the spectrum are reviews of whether medically necessary treatment is covered or excluded from a plan. These are pure coverage decisions, or, as denominated in *Pegram*, "pure eligibility decisions." 120 S. Ct. at 2154. The IRO process does not address pure eligibility decisions, because requests for clarification of coverage are specifically excluded.[17]

Third, medical necessity decisions that trigger coverage are "mixed eligibility decisions." *Id.* These decisions arise because MCOs and plans define coverage in terms of "medically necessary care." They involve the exercise of medical judgment to determine the treatment a patient needs. These are the decisions that the IRO process reviews and that the Fifth Circuit held were preempted by ERISA and FEHBA.

The Fifth Circuit held without detailed analysis that the IRO process "relates to" ERISA plans. The IRO process was subject to preemption under §514(a) because the Fifth Circuit concluded the IRO process reviews coverage decisions and was thus "squarely within the ambit of ERISA's preemptive reach." [A-13.] This reasoning is reminiscent of the reflexive

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[16] TEX. CIV. PRAC. & REM. CODE §88.003. Failure to comply with Texas' utilization review statutes, including the IRO process, does not allow an MCO to rely on §88.003 in a liability action. *Id.*

[17] TEX. INS. CODE art. 21.58A, §2(20).

approach the circuits took to "relates to" analysis after this Court's decision in *Shaw*. Then, circuits took such a literal view of "relates to" analysis that virtually any state law would be preempted.

This Court reasoned in *Travelers* that the circuits' literal interpretation of *Shaw* was erroneous because if it were valid, then "for all practical purposes preemption would never run its course." *Travelers*, 514 U.S. at 655. Notably, the Court observed that "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 661. The IRO process is health care regulation because of the nature of the decisions reviewed. They are medical in nature.

Managed care places MCOs in "an active role in determining the course and scope of medical treatment." J. Scott Anderson, *Is Utilization Review the Practice of Medicine?*, 19 J. LEGAL MED. 431, 434 (1998). MCOs are "substituting their judgment for that of the attending physician providing care." *Id.* Whether MCOs make wrong medical necessity decisions because of cost containment concerns or just poor medical judgment, the consequences are the same. In concurrent and prospective utilization review health care is affected, because the likely result of an MCO overruling the attending physician's judgment as to medical necessity "is that the patient will forego the treatment." *Id.*

The IRO process is limited to the review of concurrent and prospective requests for treatment, and thus directly implicates the health care provided to Texans. *See supra* note 4.[18] In *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321 (5th Cir.1992), the Fifth Circuit held the administrative aspect of a medical necessity decision was more important for ERISA analytical purposes than the medical aspect.[19] The Fifth Circuit acknowledged the medical aspect of the IRO process in *Corporate Health*, but steadfastly adhered to its previous analysis in *Corcoran*. [D-2-5]. This holding ignores the nature of the decisions reviewed by the IRO process, the consequences of erroneous decisions, and this Court's analysis in *Pegram*.

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[18] The *Moran* case did not involve concurrent or prospective review, in which the consequences of an erroneous decision affect the health of citizens directly and immediately. *Moran* was concerned with retrospective review to determine a reimbursement claim. The Seventh Circuit agreed "with the parties that [the independent review law] 'relates to' ERISA plans because its provisions have a connection with such plans." 2000 WL 1551659 at *8. Thus, there was no discussion of *Pegram*. Although retrospective review includes the exercise of medical judgment, the health care consequences of a patient foregoing treatment are not involved, as they are in concurrent and prospective review.

[19] *Corcoran*, 965 F.2d at 1331 ("Ultimately, we conclude that United makes medical decisions - indeed, United gives medical advice - but it does so in the context of making a benefit determination."). Commentators have criticized the Fifth Circuit's analysis because "[t]he fact that the outcome of a medical decision may entail consequences regarding whether a treatment would be paid for does not change the nature or manner of the decision." Peter D. Jacobson & Scott D. Fomfret, *Form, Function & Managed Care Torts: Achieving Fairness & Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985, 1037 (1998).

B. Texas' IRO Process Does Not "Relate to" ERISA and FEHBA Plans Under this Court's Analysis in *Pegram*.

In *Pegram*, this Court discussed the mixed nature of medical necessity decisions. 120 S. Ct. at 2154. *Pegram* concerned a claim under ERISA by a plan participant that an HMO breached its ERISA fiduciary duty because it financially rewarded doctors when they did not provide care. *Id.* at 2147. The Court reasoned that the alleged fiduciary decisions, medical necessity determinations,[20] were mixed eligibility and treatment decisions. The Court explained that:

> What we will call pure "eligibility decisions" turn on the plan's coverage of a particular condition or medical procedure for its treatment. "Treatment decisions," by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?

Id. at 2154. These "eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment." *Id.* "The eligibility decision and the treatment decisions [are] inextricably mixed, as they are in countless medical administrative decisions every day." *Id.*

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[20] The Court relied on Herdrich's brief to clarify that the breach of fiduciary duty allegations "target[ed] *medical necessity determinations*." *Pegram*, 120 S. Ct. at 2155 (emphasis added).

The medical nature of the decision reviewed by the IRO process is indisputable. The Fifth Circuit went so far as to characterize the IRO process as "simply a second opinion on medical necessity about which reasonable doctors might reach differing conclusions." [D-5.] Despite the recognition that the IRO process reviews medical decisions, the Fifth Circuit found that this Court's analysis in *Pegram* was not contrary to *Corcoran*. [D-2-3.] Although *Pegram* concerned a decision by an attending physician, not a utilization review agent, the "mixed eligibility" analysis in *Pegram* is directly applicable to this case.

This Court recognized in *Pegram* that utilization review contains a medical component. 120 S. Ct. at 2149. It is this medical component that the State seeks to regulate. In discussing the development of managed care, the Court described the method of utilization review used by MCOs to control costs and thereby affect the care provided. The Court explained that HMOs

> commonly require utilization review (in which specific *treatment decisions* are reviewed by a decisionmaker other than the treating physician) and approval in advance (precertification) for many types of care, keyed to standards of *medical necessity* or the reasonableness of the proposed treatment.

Id. (emphasis added).

The IRO process reviews the medical judgment exercised in a "mixed eligibility decision." The purpose of the IRO process is to decide whether the MCO correctly determined the "appropriate medical response" to a given "patient's constellation of symptoms." *Id.* at 2154. The issue is what medical response a patient's condition necessitates. Even though treatment and coverage decisions become inextricably mixed because of the nature of managed care, that does not change the medical nature of the decision.

Although *Pegram* was not a preemption case,[21] the Court noted that Congress did not intend ERISA to preempt general state health care regulation. "[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Id.* at 2158. The IRO addresses the central issue of health care regulation— is medical treatment necessary?

If Congress did not intend to impose ERISA fiduciary obligations on HMOs for medical necessity decisions,[22] then there is no reason to think, nor is there any legislative history to show, that Congress nevertheless intended that ERISA preempt state regulation of medical necessity decisions. Despite the immediate and apparent parallel between the Court's analysis of mixed eligibility decisions and utilization review, the Fifth Circuit did not find the Court's analysis in

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[21] *See Pegram*, 120 S. Ct. at 2154 n.9.

[22] *See Pegram*, 120 S. Ct. at 2155.

Pegram applicable. [D-2-3.] The Fifth Circuit's decision cannot be reconciled with this Court's analysis in *Pegram*.

The congressional purposes of fostering health care cost containment and preserving state health care regulation can be reconciled. The Court need only grant the petition for writ of certiorari and extend *Pegram* to hold that state independent review laws do not "relate to" ERISA and FEHBA plans[23] because there is no clear manifestation of congressional purpose to preempt state regulation of "mixed eligibility decisions." Then, while MCOs manage the costs of health care through utilization review, states can protect the health of their citizens through independent review.

III. Whether ERISA and FEHBA Preempt State Independent Review Laws is a Question of National Significance.

Many states now protect the health of their citizens through some form of independent, external review process.[24]

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[23] FEHBA preemption would be resolved because FEHBA preemption also entails a "relates to" analysis. 5 U.S.C. § 8901(m)(1).

[24] 2000 Alaska Sess. Laws 99; ARIZ. REV. STAT. ANN. § 20-2537 (West Supp. 1999); CAL. [INS.] CODE § 10169 (West Supp. 2000); COLO. REV. STAT. § 10-16-113.5 (West 1999); CONN. GEN. STAT. § 38a-478n (West Supp. 2000); DEL. CODE ANN. tit. 16, § 9119 (2000); D.C. CODE § 32-571.7 (Lexis Supp. 2000); 2000 Fla. Laws ch. 00-256 (West); GA. CODE ANN. § 33-20A-32 (2000); 2000 Haw. Sess. Laws 250; 215 ILL. COMP. STAT. 125/4-10 (West Supp. 2000); IND. INS. CODE ANN. § 27-13-10.1-1 (West 2000); IOWA CODE ANN. § 514J (West 2000); KAN. STAT. ANN. § 40-22a13 (Supp. 1999); 2000 Kentucky Laws Reg. Sess. 262 (West); LA. REV. STAT. ANN. § 22:3081(2000); 2000 Me. Legis. Serv. 742

When an MCO makes an erroneous medical necessity decision, the likely result is that the patient will forego needed treatment. This can lead to tragic consequences. Neither ERISA nor FEHBA provide this critical patient protection. Whether ERISA and FEHBA preempt state laws creating independent reviews of MCO medical necessity decisions is thus a question of paramount importance worthy of Supreme Court review.

Independent review "serves as a safety valve" to correct mistakes or ill-advised decisions by MCOs.[25] "[C]oncerns about managed care incentives that might lead to the inappropriate denial of care" are likewise addressed by

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(West); MD. CODE ANN. [INS.] §§ 15-10A through 15-10B (Lexis Supp. 1999); 2000 Mich. Legis. Serv. 251 (West); MINN. STAT. ANN. § 62Q.73 (West Supp. 2000); MO. REV. STAT. § 376.1385 (1997); MONT. CODE ANN. § 33-37-102 (1999); N.H. REV. STAT. ANN. 420-J:5 (2000); N.J. STAT. ANN. §§ 26:2S-11, 26:2S-12 (West Supp. 2000); N.M. ADM. CODE tit. 13, § 10.17.24 (Michie Supp. 2000); N.Y. [INS.] LAW §§ 4904 (McKinney 1999); N.C. GEN. STAT. §§ 58-50-61, 58-50-62 (1998); OHIO REV. CODE ANN. § 1751.84 (Baldwin Supp. 2000); OKLA. STAT. ANN. tit. 63, § 2528.3 (West 1999); 40 PA. CONS. STAT. §§ 991.2161 *et seq.* (1998); R.I. GEN. LAWS § 23-17.12-10 (Lexis Supp. 2000); 2000 S.C. Acts 380; TENN. CODE ANN. § 56-32-227 (West 1999); UTAH CODE ANN. § 31A-22-629 (2000); VT. STAT. ANN. tit. 8, § 4089f (1998); VA. CODE § 38.2-5900 to 38.2-5905 (Michie Supp. 2000); 2000 Wash. Legis. Serv. 5 (West); 2000 Wisc. Legis. Serv. 155 (West).

[25] Karen Pollitz, Geraldine Dallek, and Nicole Tapay, Institute for Health Care Research and Policy Georgetown University, *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare* (Nov. 1998), p.49 <http://www.kff.org/content/ archive/1443/review_r.pdf> (prepared for the Henry J. Kaiser Family Foundation.)

independent review.[26] Because of these salutary effects, in addition to Texas, thirty-seven states and the District of Columbia have established some form of external review.

The states have a right to establish checks and balances over managed care through independent review laws that protect the health and well-being of their citizens. Nothing in the language of ERISA or FEHBA or their legislative history supports the Fifth Circuit's conclusion that Congress gave MCOs carte blanche to substitute their medical judgment for that of an attending physician's free of state regulation. This misconception of the purpose and intent of Congress in enacting ERISA and FEHBA should be dispelled by this Court.

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[26] Geraldine Dallek and Karen Pollitz, Institute for Health Care Research and Policy Georgetown University, *External Review of Health Plan Decisions: An Update* (May 2000), p.1, <http://www.kff.org/content/archive/3020/review_r.pdf> (prepared for the Henry J. Kaiser Family Foundation.).

CONCLUSION

For these reasons, the petition for writ of certiorari should be granted.

Respectfully submitted,

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No.

In the Supreme Court of the United States

JOSE MONTEMAYOR, COMMISSIONER OF THE TEXAS DEPARTMENT OF INSURANCE; JOHN CORNYN, ATTORNEY GENERAL OF TEXAS,
Petitioners,

v.

CORPORATE HEALTH INSURANCE, INC.; AETNA HEALTH PLANS OF TEXAS, INC.; AETNA HEALTH PLANS OF NORTH TEXAS, INC.; AETNA LIFE INSURANCE COMPANY,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

APPENDIX TO PETITION FOR WRIT OF CERTIORARI

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IN THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

NO. 98-20940

CORPORATE HEALTH INSURANCE, INC.;
AETNA HEALTH PLANS OF TEXAS, INC.;
AETNA HEALTH PLANS OF NORTH TEXAS, INC.;
AETNA LIFE INSURANCE COMPANY
Plaintiffs - Appellees-Cross-Appellants,

v.

THE TEXAS DEPARTMENT OF INSURANCE
Defendant - Cross-Appellee,
JOSE MONTEMAYOR, COMMISSIONER OF THE TEXAS
DEPARTMENT OF INSURANCE; JOHN CORNYN,
ATTORNEY GENERAL, STATE OF TEXAS
Defendants - Appellants-Cross-Appellees.

On Appeal from the United States District Court
for the Southern District of Texas,
Houston Division

June 20, 2000

Before HIGGINBOTHAM and PARKER, Circuit Judges,
and ATLAS, District Judge.[1]

HIGGINBOTHAM, Circuit Judge:

Large changes in the delivery systems for medical services, including the growth of health maintenance organizations ("HMOs") and managed care organizations ("MCOs"), came as rapid responses to rising costs for medical services and to the growth of medical expense reimbursement for employees. These new entities injected an intermediary between doctor and patient in setting medical care charges and making payments; at the same time, the insurance industry began to offer administrative services to employers and to contract with doctors for services at set rates. Billions of dollars now flow through these structures, generating equally large difficulties of governance and daily tensions between quality and quantity.

Through much of this period, the preemptive reach of ERISA made regulation of this market largely a federal enterprise, shared with the states at its juncture points with insurance. Today we decide questions regarding the ability of the State of Texas to regulate the quality of health services when such efforts impose a duty of care upon service providers to ERISA plans.

I

This suit is a preemption challenge to Texas's Senate Bill 386.[2] Through that legislation, Texas asserted its police power to protect its citizens in regulating the new field of managed health care in three ways. First, it created a statutory cause of action against managed care entities that fail to meet an ordinary care standard for health care treatment decisions

(the "liability" provisions). Second, it established procedures for the independent review of health care determinations to decide whether they were appropriate and medically necessary (the "independent review" provisions). Finally, it protected physicians from HMO-imposed indemnity clauses and from retaliation by HMOs for advocating medically necessary care for their patients.

The plaintiffs, Corporate Health Insurance, Inc., Aetna Health Plans of Texas, Inc., Aetna Plans of North Texas, Inc. and Aetna Life Insurance Company,[3] are not ERISA plans. Aetna Health Plans of Texas is an HMO licensed by the State of Texas that contracts with more than 2,900 independent health care providers and 39 hospitals. Aetna Life Insurance Company sells various health insurance products to employers, including programs available through a preferred provider organization. In Texas, nearly one million individuals participate in a managed care program of Aetna or one of its affiliated entities.

Senate Bill 386 became effective on May 22, 1997. Aetna promptly filed suit in the United States District Court, claiming that the Act was preempted by ERISA's general preemption clause, section 514, which preempts "any and all state laws insofar as they . . . relate to any employee benefit plan"[4] and by the Federal Employees Health Benefit Act ("FEHBA").[5] The plaintiffs named as defendants John Cornyn, the Attorney General of Texas, Jose Montemayor, Commissioner of the Texas Department of Insurance, and the Department of Insurance itself. The Commissioner remains a party, but the Department of Insurance has been dismissed.[6]

The parties filed cross-motions for summary judgment, which the district court granted in part and denied in part. The district court found no FEHBA or ERISA preemption of the liability provisions of Senate Bill 386 but found that ERISA preempted the anti-retaliation, anti-indemnification, and independent review provisions of the legislation. Both Aetna and Texas appeal.

II

Texas argues that Aetna lacks standing to challenge the Act's new standards for liability. Texas contends that Aetna has not suffered the requisite injury under Article III because Aetna has thus far been exposed to a duty of care and will have standing only if it defends a private suit for the breach of that duty. Texas concedes that Aetna has standing to challenge the other provisions given the Commissioner's oversight authority. Aetna replies that it has standing because the liability provisions expose it not only to private suits but also to the regulatory reach of the Attorney General. We agree. This is not a case in which private suits are the only means of enforcing a challenged statutory standard. The Attorney General can pursue Aetna through an action under the Texas Deceptive Trade Practices Act and the Insurance Code.[7] This regulatory oversight is sufficient to create the requisite imminent injury for standing.

III

We have repeatedly struggled with the open-ended character of the preemption provisions of ERISA and FEHBA.[8] We

faithfully followed the Supreme Court's broad reading of "relate to" preemption under § 502(a) in its opinions decided during the first twenty years after ERISA's enactment. Since then, in a trilogy[9] of cases, the Court has confronted the reality that if "relate to" is taken to the furthest stretch of its indeterminacy, preemption will never run its course, for "really, universally, relations stop nowhere."[10] Justice Souter, speaking for a unanimous court in Travelers, acknowledged that "our prior attempt to construe the phrase 'relate to' does not give us much help drawing the line here." Rather, the Court determined that it "must go beyond the unhelpful text . . . and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive."[11]

In Travelers, a New York statute required hospitals to collect surcharges from patients insured by a commercial carrier but not from certain HMOs. The plain purpose of the surcharge was to encourage the HMOs to provide open enrollment coverage. The Second Circuit found that the surcharges "related to" ERISA plans because they imposed economic burdens with an impermissible impact on plan administration and structure. In rejecting the Second Circuit's approach, and in shifting its own approach, the Court observed that such indirect economic influences "d[id] not bind plan administrators to any particular choice," but rather affected the costs of benefits and the "relative costs of competing insurance to provide them."[12] The Court grounded the "relate to" clause in the complex realities of the market for medical services.

Dillingham, the second of the trilogy, came two terms later.

The case challenged a California law which required public works contractors to pay a prevailing wage but allowed lower wages to be paid in qualified apprenticeship programs. A unanimous Court found the law not preempted, holding that regulation of the underlying industry of which the employers were members does not require preemption. The Court began with the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."[13] Justice Scalia, in a concurring opinion joined by Justice Ginsburg, urged the Court to acknowledge directly that it had returned to traditional preemption analysis and that "relate to" states no special test but rather identifies the field in which ordinary field preemption applies.[14]

Four months later, the Court handed down De Buono, upholding New York's tax on gross receipts for patient services at health care facilities. The Court again rejected the theory that the effects of even a direct tax on an ERISA plan required a finding of preemption. The Court was persuaded that the tax was not the type of state law that Congress intended ERISA to preempt.[15]

In each of these three cases, the Court was returning to a traditional analysis of preemption, asking if a state regulation frustrated the federal interest in uniformity.[16] This analysis is similar to the Court's approach in determining whether state law is preempted by federal common law[17] - even there, where the conflict between federal policy and state law need

not be as sharp as for preemption when Congress legislates in a field that the states have traditionally occupied, the Court has insisted on a significant conflict with an "identifiable federal policy or interest."[18] And significantly for our case, this return has included the observation that a broader reading of "relates to" would sweep away common state action with indirect economic effects on the costs of health care plans, such as quality standards which may vary from state to state.

IV

This brings us to the merits of the claim that Senate Bill 386 is preempted. We turn first to its liability provisions. In Section 88.002, the bill provides:

A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.[19]

The statute gives "health care treatment decision" a defined meaning:

[A] determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.[20]

The Act also defines the agents for whose health care decisions the entities can be vicariously liable.[21] Further, the Act includes a disclaimer: it avoids imposing any obligation on the entity "to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity."[22]

Aetna argues that the liability provisions "relate to" an ERISA plan and affect plan administration. Aetna contends that a claim that medical services were negligently provided will inevitably question the provider's determinations of coverage under an ERISA plan. Texas replies that Senate Bill 356 has avoided the difficult genre of cases complaining of medical care and service which were not provided by excluding a duty to provide treatment not covered by a plan.

We agree with Texas's interpretation of the Act. When the liability provisions are read together, they impose liability for a limited universe of events. The provisions do not encompass claims based on a managed care entity's denial of coverage for a medical service recommended by the treating physician: that dispute is one over coverage, specifically excluded by the Act. Rather, the Act would allow suit for claims that a treating physician was negligent in delivering medical services, and it imposes vicarious liability on managed care entities for that negligence.

This vicarious liability does not "relate to" the managed care provider's role as an ERISA plan administrator or affect the structure of the plans themselves so as to require preemption. Courts have observed that HMOs and MCOs typically perform two independent functions -- health care insurer and

medical care provider.[23] A managed care entity can provide administrative support for an insurance plan, which may entail determining eligibility or coverage. At the same time, a managed care entity can act as an arranger and provider of medical treatment.

Although state efforts to regulate an entity in its capacity as plan administrator are preempted,[24] managed care providers operate in a traditional sphere of state regulation when they wear their hats as medical care providers. ERISA preempts malpractice suits against doctors making coverage decisions in the administration of a plan, but it does not insulate physicians from accountability to their state licensing agency or association charged to enforce professional standards regarding medical decisions.[25] Such accountability is necessary to ensure that plans operate within the broad compass of sound medicine. We are not persuaded that Congress intended for ERISA to supplant this state regulation of the quality of medical practice.[26] While it may impose some indirect costs on ERISA plans, the Court has considered such effects too tenuous to require preemption.

We also are not persuaded that the liability provisions are preempted as "referring to" ERISA plans. Under this strain of preemption analysis, we examine whether the law acts immediately and exclusively upon ERISA plans or whether the existence of an ERISA plan is essential to the law's operation.[27] A law does not "refer to" ERISA plans if it applies neutrally to ERISA plans and other types of plans.[28] Aetna asserts that the definitions of "health care treatment decision" and "health care plan" refer to ERISA plans because

they make reference to "plans."[29] We disagree. The provisions are indifferent to whether the health care plan operates under ERISA and do not rely on the existence of ERISA plans for their operation.[30]

We see nothing to take the liability provisions from the regulatory reach of states exercising their traditional police powers in regulating the quality of health care. A suit for medical malpractice against a doctor is not preempted by ERISA simply because those services were arranged by an HMO and paid for by an ERISA plan. Likewise, the vicarious liability of the entities for whom the doctor acted as an agent is rooted in general principles of state agency law. Seen in this light, the Act simply codifies Texas's already-existing standards regarding medical care. These standards of care are at the heart of Texas's regulatory power.

V

We turn to the anti-retaliation and anti-indemnification provisions under sections 88.002(f) and (g) of the Act. The anti-retaliation provision forbids a managed care entity from dropping or refusing to renew a doctor or health care provider for advocating medically necessary treatment.[31] The anti-indemnification provision prohibits a managed care entity from including an indemnification clause in its contracts with doctors and other health care providers that would hold it harmless for its own acts.[32] Aetna contends that these provisions improperly mandate the structure and administration of ERISA plan benefits because ERISA plans are forced to contract with doctors only on those terms.

We are not persuaded that these provisions mandate the structure and administration of plans. Our analysis again stems from our recognition that HMOs and MCOs perform functions both as health care insurers and as medical care providers. The anti-indemnity and anti-retaliation rules govern the managed care entities as health care providers by regulating the terms on which the provider contracts with its agents. The rules do not compel the entities to provide any substantive level of coverage as health care insurers.

Our past cases addressing "any willing provider" statutes are consistent with this analysis. In those cases, the state statutes at issue required managed care entities to contract with any pharmacy willing to do business on the entity's terms.[33] Because those state laws essentially mandated that plan beneficiaries could choose from a larger pool of providers, they affected substantive plan benefits in a way that the provisions at issue here do not.[34]

The anti-retaliation and anti-indemnity provisions complement the Act's liability provisions by realigning the interests of managed care entities and their doctors. The liability and indemnity provisions force the managed care entity to share in its doctors' risk of tort liability; the anti-retaliation provision avoids the situation in which the doctor must choose between satisfying his professional responsibilities and facing retaliatory action by the managed care entity. Together, the provisions thus better preserve the physician's independent judgment in the face of the managed care entity's incentives for cost containment. Such a scheme is again the kind of quality of care regulation that has been left to the states.[35]

VI

We come to the statute's provisions for independent review of determinations by managed care entities. The authorization for such review is codified at several locations in the Texas Code.

The first set of provisions, codified in section 88, allows suit against an entity only after the patient has followed an independent review procedure.[36] The provision describes the patient's complaint as "the claim," which refers back to the basis of the cause of action.[37] This language allows independent review only of claims for which patients may bring suit under the liability provisions. As such, the review provisions are not preempted. Any duty imposed on managed care entities by the independent review provisions extends no further than that imposed by the liability provisions. Moreover, because the 1999 amendments to the section make such review voluntary on the entity's part,[38] the entity cannot complain that the provision is at odds with its duties under ERISA.

Another set of provisions, codified at various sections of the Insurance Code,[39] does not appear to so limit independent review. The Act adds procedures through which patients may appeal "adverse determinations" --

> [A] determination by [an HMO] or utilization review agent that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary or are not appropriate.[40]

The Act further requires that a utilization review agent "comply" with the independent review organization's determination of medical necessity.[41]

It is apparent that "adverse determinations" include determinations by managed care entities as to coverage, not just negligent decisions by a physician. The provisions allow a patient who has been denied coverage to appeal to an outside organization.[42] Such an attempt to impose a state administrative regime governing coverage determinations is squarely within the ambit of ERISA's preemptive reach.[43]

VII

Texas and the federal government urge that the preempted independent review provisions are saved under ERISA's saving clause for laws regulating insurance.[44] The Supreme Court has interpreted the clause as designed to preserve Congress's reservation of the business of insurance to the states under the McCarran-Ferguson Act.[45] In determining whether the clause applies, the Supreme Court considers whether the rule regulates insurance as a commonsense matter, looking as well to the three McCarran-Ferguson factors as "guideposts:" (1) whether the practice has the effect of transferring or spreading the policyholder's risk; (2) whether it is an integral part of the policy relationship between the insured and the insurer; and (3) whether the practice is limited to entities in the insurance industry.[46] The law need not satisfy each of these tests.[47]

The common sense test measures whether the law is specifically directed toward the insurance industry.[48] A law is

so aimed when the state has developed a specific scheme governing insurance, as opposed to a flexible rule used in many legal contexts.[49] Here, the independent review provisions create a regulatory scheme governing health benefit determinations. They do not rely on general legal rights used in other areas of law.

That the provisions apply to managed care entities as well as to traditional insurers does not exclude them from the saving clause. In determining whether a statute regulates the insurance industry, courts have examined whether a statute governs only entities acting as insurers. A statute may regulate insurance if it applies to insurers, health care service contractors, and HMOs.[50] If the law sweeps more broadly, however, covering employers and others not engaged in insurance practices, it cannot be said to be regulating insurance.[51] Our own cases are consistent with this distinction.[52] Here, the preempted provisions apply to HMOs[53] and to utilization review agents for insurers, administrators, and non-ERISA health benefit plans.[54] In making benefit determinations, these entities are functioning as insurers.

The common sense test also considers whether the law plays an integral part in the policy relationship between the insured and the insurer. Laws that create a mandatory contract term between the parties, including procedural requirements, go to the core insured-insurer relationship.[55] Here, the independent review provisions create a procedural right of the insured against the entity. As the independent review provisions are aimed at insuring entities and regulate the insured-insurer

relationship, they meet the common sense test of the saving clause.

For the same reasons, the provisions satisfy the second and third prongs of the McCarran-Ferguson test: they are integral to the policy relationship and regulate the insurance industry. While the provisions probably do not meet the first factor of reallocating the risk between the insured and insurer, that failure is not fatal to Texas's saving clause claim.

Our analysis does not end here, however, because even if the provisions would otherwise be saved, they may nonetheless be preempted if they conflict with a substantive provision of ERISA.[56] In Pilot Life v. Dedeaux, the Supreme Court held that "our understanding of the saving clause must be informed by the legislative intent concerning [ERISA's] civil enforcement provisions."[57] The Court interpreted Congress's intent regarding the exclusivity of ERISA's enforcement scheme very broadly, concluding that the scheme preempts not only directly conflicting remedial schemes, but also supplemental state law remedies.[58] Thus, the saving clause does not operate if the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan.[59]

Here, the independent review provisions do not create a cause of action for the denial of benefits. They do, however, establish a quasi-administrative procedure for the review of such denial and bind the ERISA plan to the decision of the independent review organization. This scheme creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan - the identical

relief offered under § 1132(a)(1)(B) of ERISA. As such, the independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the saving clause.[60]

VIII

Aetna argues that all of the provisions at issue are preempted by the terms of plans operating under FEHBA, the statute governing federal employee health insurance. The preemption language of that statute reads:

> The terms of any contract under this chapter . . . which relate to the nature, provision, or extent of coverage or benefits (including payment with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.[61]

The statute was amended in 1998 to add a "relate to" clause like that in ERISA.

The provisions of the Texas Act that we have held do not "relate to" ERISA plans similarly would not "relate to" any FEHBA plans because they do not concern coverage or benefits.[62] As we have construed those provisions, they address only managed care entities' duties as health care providers, not as insurers. While Congress has an identifiable federal interest in providing uniform benefits to government employees,[63] there is no significant conflict here between that interest and Texas's regulation of quality of medical care. And we decline to require FEHBA preemption simply because state regulation might indirectly increase the costs of managed care.

As to the independent review provisions which would be ERISA-preempted, we find that FEHBA plans would preempt such review under general conflict principles. The independent review provisions specifically conflict with the administrative remedy provided by the Office of Personnel Management concerning benefits disputes.[64]

IX

As we have found some of the Act's provisions preempted, we must consider whether they are severable from the remainder of the statute. Severability turns on the intent of the state legislature; we examine whether the provisions are so independent that the legislature would have passed the remaining statute without the disallowed provisions.[65]

After the district court's determination holding the IRO provisions preempted, the Texas Legislature passed a bill making those procedures optional as to the liability provisions.[66] Although that amendment does not apply to the independent review provisions we have held preempted, we find it instructive as to the legislature's intent regarding independent review generally. As the district court noted, it appears that the legislature was concerned both with the quality of care and with denials of care. While the review provisions regarding the denial of care are preempted under ERISA and FEHBA, we find that the legislature would nonetheless wish to give effect to those provisions targeting the quality of care.

We sever articles 20A.12A, 21.58A § 6(c), and 21.58A §6 A, as well as those portions of 20A.09(e) and 21.58A § 6(b) amended by the Act, from the remainder of the Act and hold them preempted. We conclude that the liability provisions of the Texas statute, and the independent review provisions insofar as they are merely a prerequisite to the filing of suit, are preempted neither under ERISA nor FEHBA because they allow suit only for health services actually delivered, not for coverage disputes. We also find that the anti-indemnity and anti-retaliation provisions are not preempted: they too address traditional state concerns regarding the quality of health care.

AFFIRMED IN PART; REVERSED IN PART.

1. District Judge of the Southern District of Texas, sitting by designation.

2. Codified at Tex. Civ. Prac. & Rem. Code § 88.001 et seq.; Tex. Ins. Code art. 20A.09(e) (formerly (a)(3)), 20A.12(a) and (b), 20A.12A, 21.58A §6(b) and (c), 21.58A §6A, 21.58A §8(f) & 21.58C.

3. We will refer to the plaintiffs generally as "Aetna."

4. 29 U.S.C. § 1144(a).

5. 5 U.S.C. § 8901 et seq.

6. We will refer to the defendants generally as "Texas." The United States Secretary of Labor is charged with interpreting and enforcing all provisions of Title I of ERISA, see 29

U.S.C. 1001 et seq., but not FEHBA. The Secretary filed an amicus brief and participated in oral argument in this case. We will refer to the Secretary as the federal government.

7. On the Attorney General's right of action, see Tex. Ins. Code Ann. art. 21.21 § 15(a); Tex. Bus. & Com. Code Ann. § 17.47. Relevant provisions imposing liability include Tex. Ins. Code Ann. art. 21.21-2 §2(b)(5) (unfair and deceptive to compel policyholders to institute suits to recover amounts due); art. 21.21 §4(10)(ii) (prohibiting the failure to pay claims when liability has become reasonably clear); id. at art. 21.21-2(B)(4) (same).

8. See, e.g., CIGNA Healthplan of La., Inc. v. Louisiana, 82 F.3d 642 (5th Cir. 1996); Corcoran v. United HealthCare, Inc., 965 F.2d 1321 (5th Cir. 1992).

9. De Buono v. NYSA-ILA Med. & Clinical Serv's Fund, 117 S. Ct. 1747 (1997); California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 117 S. Ct. 832 (1997); New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671 (1995).

10. Travelers, 115 S. Ct. at 1677.

11. Id.

12. Id. at 1679.

13. Dillingham, 117 S. Ct. at 838 (quoting Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947)).

14. Id. at 843 (Scalia, J., concurring).

15. De Buono, 117 S. Ct. at 1752.

16. See also Boggs v. Boggs, 117 S. Ct. 1754 (1997) (analyzing whether state community property law frustrates federal interests in determining ERISA preemption).

17. Boyle v. United Tech Corp., 487 U.S. 500 (1988).

18. Boyle, 487 U.S. at 507.

19. Tex. Civ. Prac. & Rem. Code Ann. § 88.002(a) (1999).

20. § 88.001(5).

21. § 88.002(b).

22. § 88.002(d).

23. See Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 360-61 (3d Cir. 1995); Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc., 958 F. Supp. 1137, 1139 n.2 (E.D. Va. 1997).

24. Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1, 9 (1987).

25. This distinction is consistent with Corcoran's holding that medical decisions involving coverage determinations are preempted.

26. The Second, Third, and Seventh Circuits have held that medical negligence claims against HMOs for vicarious and direct liability are not within the scope of § 502(a) and, therefore, are not completely preempted because they involve conduct by the HMO in its capacity as a provider and arranger of health services and not as plan administrator. See Rice v. Panchal, 65 F.3d 637, 646 (7th Cir. 1995) (vicarious claims); Dukes, 57 F.3d at 356 (vicarious and direct claims); Lupo v. Human Affairs Int'l, Inc., 28 F.3d 269, 272 (2d Cir. 1994) (direct claims). District courts have also allowed suit for vicarious liability. See Ray v. Value Behavioral Health, Inc., 967 F. Supp. 417, 423-24 (D. Nev. 1997); Yanez v. Humana Medical Plan, Inc., 969 F. Supp. 1314, 1316 (S.D. Fla. 1997); Schachter v. Pacificare of Okla., Inc., 923 F. Supp. 1448, 1451 (N.D. Okla. 1995); Chaghervand v. CareFirst, 909 F. Supp. 304, 311 (D. Md. 1995); Smith v. HMO Great Lakes, 852 F. Supp. 669, 671-72 (N.D. Ill. 1994).

27. See Dillingham, 117 S. Ct. at 837-38.

28. Id. at 839; see also District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 127 (1992) (holding law referred to ERISA plans because it targeted employers to provide certain health insurance coverage to their employees, an obligation under law by reference to ERISA). Our decision in CIGNA is distinguishable: there, the statute contained an explicit reference to employers. CIGNA, 82 F.3d at 648.

29. See § 88.001(2) and (5).

30. We also decline to hold the entire Act preempted on the basis that some of its independent review provisions are codified in a statute that includes an explicit exclusion of ERISA plans. Even if such mention required preemption of the exclusionary provision itself (a provision not challenged in this suit), or of other statutory provisions which it affected, it could have no preemptive effect on the Act's provisions codified elsewhere in the Texas Code.

31. See Tex. Civ. Prac. & Rem. Code § 88.002(f).

32. See § 88.002(g).

33. See Texas Pharmacy Ass'n v. Prudential Ins. Co., 105 F.3d 1035, 1036 (5th Cir. 1997); CIGNA, 82 F.3d at 645.

34. In addition, those cases were decided before Dillingham and DeBuono. The Texas Pharmacy court noted that its holding was only valid pending further guidance from the Supreme Court. See Texas Pharmacy, 105 F.3d at 1039-40.

35. The Supreme Court's most recent discussion of ERISA confirms this analysis. In Pegram v. Herdrich, the Court held that ERISA confers no cause of action against HMOs for providing incentives to their doctors for limiting the costs of testing and treatment. Part of the Court's reasoning was that states are currently allowed to impose malpractice liability on HMOs for such action. 530 U.S. ____, [24] (June 12, 2000).

36. See Tex. Civ. Prac. & Rem. Code § 88.003.

37. See id.

38. See § 88.003(a) and (c).

39. See Tex. Ins. Code art. 20A.09(e) (codified in 1997 at 20A.09(a)(3)) and 20A.12A (amendments to the Texas Health Maintenance Organization Act); 21.58A §6(b) and (c) and §6A (amendments to the Utilization Review Agent Act).

40. Art. 20A.12A(a)(1) (codified in 1997 in slightly amended form at 20A.12(c)(1)).

41. Art. 21.58A §6A(3). The provision refers specifically to "utilization review agents" for insurers and administrators. HMOs are directed to follow the rules applicable to utilization review agents. See art. 20A.12A(b).

42. Texas notes that the provisions of the Act codified in the state's utilization review agent ("URA") statute, Tex. Ins. Code art. 21.58A, may not even apply to ERISA plans. The URA statute includes an exclusion for ERISA plans - "This article shall not apply to the terms or benefits of employee welfare benefit plans as defined in . . . [ERISA]." § 14(e). Texas states that its Insurance Commissioner generally treats such provisions as excluding self-funded ERISA plans, not insured ERISA plans. To the extent the provisions regulate insurers for ERISA plans, they still "relate to" ERISA plans and are preempted.

43. This preemption does not reach three provisions of the Act codified in the Insurance Code which do not create a right to independent review: Tex. Ins. Code art. 21.58C (setting forth general standards and rules for independent review

organizations); 21.58A §8(f) (confidentiality provision); and 20A.12(a) and (b) (making minor changes to preexisting provision).

44. 29 U.S.C. § 1144(b)(2)(A) (1999).

45. See Metropolitan Life Ins. v. Massachusetts, 471 U.S. 724, 744 n.21 (1985).

46. See UNUM Life Ins. Co. v. Ward, 119 S. Ct. 1380, 1386 (1999).

47. See Ward, 119 S. Ct. at 1389.

48. See id. at 1387-88.

49. See id. (law met the common sense test because the state had developed a specific scheme governing the rights of an insured); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 51 (1987) (the state's common law of bad faith, developed from tort and contract law generally, was not an integral part of the policy relationship).

50. See Washington Physicians Serv. Ass'n v. Gregoire, 147 F.3d 1039, 1045 (9th Cir. 1998).

51. See Prudential Ins. Co. of America v. National Park Med. Ctr., Inc., 154 F.3d 812, 825 (8th Cir. 1998) (distinguishing Gregoire based on scope of statute).

52. See Texas Pharmacy, 105 F.3d at 1039 (not insurance regulation where law applied to employers and pharmacy groups as well as HMOs); CIGNA, 82 F.3d at 650 (not regulation where rule applied to self-funded organizations and employers).

53. See Tex. Ins. Code art. 20A.12A.

54. See 21.58A § 2(21); § 14(e) (excluding ERISA plans).

55. See Ward, 119 S. Ct. at 1390 & n.5.

56. See id. at 1390.

57. Pilot Life, 481 U.S. at 52. ERISA's enforcement provisions are set out at 29 U.S.C. § 1132.

58. Id. at 56.

59. See Kanne v. Connecticut Gen. Life Ins. Co., 867 F.2d 489, 493-94 (9th Cir. 1988); In re Life Ins. of North America, 857 F.2d 1190, 1194-95 (8th Cir. 1988). But see Franklin H. Williams Ins. Trust v. Travelers Ins. Co., 50 F.3d 144, 151 (2d Cir. 1995).

60. In Ward, the Supreme Court noted the federal government's change in position since Pilot Life on the issue of whether a provision in conflict with ERISA's enforcement provision is nevertheless saved by the saving clause. Because the issue was not necessary to the resolution of the case,

however, the Court declined to revisit it. See Ward, 119 S. Ct. at 1390 n.7.

61. 5 U.S.C. § 8902(m)(1) (1999).

62. See also Negron v. Patel, 6 F. Supp.2d 366, 371 (E.D. Pa. 1998) (vicarious liability claim not preempted by FEHBA).

63. See Caudill v. Blue Cross & Blue Shield of N.C., 999 F.2d 74, 78 (4th Cir. 1993).

64. 5 U.S.C. § 8902(j); 5 C.F.R. § 890.105 - 890.107; see also Bryan v. Office of Personnel Management, 165 F.3d 1315, 1318 (10th Cir. 1999) (FEHBA creates only one remedy for the administrative review of benefit denials).

65. See Association of Tex. Educators v. Kirby, 788 S.W.2d 827, 830 (Tex. 1990).

66. See Tex. S.B. 1884, 76th Leg., R.S. (1999), Bill Analysis.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CORPORATE HEALTH INSURANCE INC., ET AL.	§	
	§	
	§	
versus	§	**CIVIL ACTION**
	§	**NO. H-97-2072**
THE TEXAS DEPARTMENT OF INSURANCE, ET AL.	§	
	§	

ORDER

Pending before the Court are Defendants' motion to dismiss, which has been converted into a motion for summary judgment, (Instrument No. 10), and Plaintiffs' motion for summary judgment, (Instrument No. 20). Based on the parties' submissions and the applicable law, the Court finds that Defendants' and Plaintiffs' motions should be **GRANTED in PART** and **DENIED in PART**.

I. Background

Plaintiffs Corporate Health Insurance, Inc., Aetna Health Plans of Texas, Inc., Aetna Health Plans of North Texas, Inc., and Aetna Life Insurance Company bring this action against Defendants Texas Department of Insurance (the "Department") and Elton Bomer ("Bomer"), Commissioner of the Texas Department of Insurance, and Dan Morales ("Morales"), Attorney General of the state of Texas, in their

official capacities, seeking declaratory and injunctive relief. Plaintiffs request a declaration that Texas Senate Bill 386, the Health Care Liability Act (the "Act"), codified as TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 (West 1998), and which adds or amends TEX. INS. CODE ANN. arts. 20A.09, 20A.12, 20A.12A, 21.58A, and 21.58C (West 1998), is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C.A. § 1001 *et seq.* (West 1985 & Supp. 1998), and by the Federal Employees Health Benefit Act ("FEHBA"), 5 U.S.C.A. § 8901 *et seq.* (West 1967 & Supp. 1996). Plaintiffs also seek, if necessary, to enjoin the enforcement of the Act as it relates to employee benefit plans covered by ERISA and FEHBA.

The Act allows an individual to sue a health insurance carrier, health maintenance organization, or other managed care entity for damages proximately caused by the entity's failure to exercise ordinary care when making a health care treatment decision. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West 1998). In addition, under the Act, these entities may be held liable for substandard health care treatment decisions made by their employees, agents, or representatives. *Id.* § 88.002(b).[1] The Act also establishes an

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[1]The Act provides, in pertinent part, the following:
§ 88.002. Application
(a) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure ro exercise

independent review process for adverse benefit determinations and requires an insured or enrollee to submit his or her claim challenging an adverse benefit determination to a review by an independent review organization if such a review is requested by the managed care entity. *Id.* § 88.003(c). Additional responsibilities for HMOs and further requirements concerning the review of an adverse benefit determination by an independent review organization are also addressed by the Act. *See* TEX. INS. CODE ANN. arts. 20A.09, 20A.12, 20A.12A, 21.58A, and 21.58C (West 1998).

On July 21, 1997, Defendants filed a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim and to dismiss Plaintiffs' suit against the Department and Bomer as improper parties. Defendants argue that dismissal is appropriate for the following reasons:

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such ordinary care.

(b) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its:

(1) employees;
(2) agents;
(3) ostensible agents; or
(4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.

TEX. CIV. PRAC & REM. CODE ANN. §§ 88.002(a) and (b) (West 1998).

> Senate Bill 386 regulates the quality of care provided by the HMO[s] operating in Texas. ERISA and FEHBA, in contrast, govern what types of regulations may be placed on an employee benefit plan. The plain meaning of the statute shows that the purpose of Senate Bill 386 is to prevent health plans from escaping liability for the medical decisions they "make," "control" or "influence." Senate Bill 386 does not seek to regulate how HMO's make benefit or coverage determinations; nor does it proscribe requirements governing the *structure* of a benefit plan. Accordingly, the ERISA and FEHBA preemption clauses do not apply to Senate Bill 386.

(Defendants' Summary of Argument, Instrument No. 25 at 1). If the Court were to determine that certain provisions of the Act relate to employee welfare benefit plans, Defendants ask this Court to sever any "non-liability" provisions of the Act that it finds to be preempted, saving the valid quality of care liability provisions. (Defendants' Reply, Instrument No. 24 at 8 n.3). Defendants also contend that the Eleventh Amendment bars suit against both the Texas Department of Insurance and Bomer because the state of Texas is immune from suit. Furthermore, according to Defendants, there is "a real question" as to whether Elton Bomer is a proper party given the Plaintiffs' allegations in their complaint. (Defendants' Brief, Instrument No. 11 at 38 n.37).

On July 29, 1997, Plaintiffs filed a motion for summary judgment, contending that the Act "impermissibly interferes with the purpose, structure and balance of ERISA and

FEHBA, thereby injecting state law into an area exclusively reserved for Congress." (Plaintiffs' Summary of Argument, Instrument No. 21 at 1). Plaintiffs contend that the language in the Act expressly "refers to" ERISA plans, and that the Act has a connection with ERISA plans because it purports to impose state law liability on ERISA entities and to mandate the structure of plan benefits and their administration. Plaintiffs also maintain that the Act wrongfully binds employers and plan administrators to particular choices and impermissibly creates an alternate enforcement mechanism.

On April 24, 1998, the Court held a hearing on Defendants' motion to dismiss and Plaintiffs' motion for summary judgment. At the hearing, the Court informed the parties that Defendants' motion to dismiss would be converted into a motion for summary judgment. Then, on May 15, 1998, Plaintiffs filed their First Amended Complaint for Declaratory Judgment and Permanent Injunction, adding Morales as a defendant in this case.

II. 12(b)(6) Motion to Dismiss Standard of Review

Rule 12(b)(6) allows for dismissal if a plaintiff fails "to state a claim upon which relief may be granted[.]" FED. R. CIV. P. 12(b)(6). Such dismissals, however, are rare, *Clark v. Amoco Prod. Co.*, 794 F.2d 967, 970 (5th Cir. 1986), and only granted where "it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Conley v. Gibson*, 355 U.S. 41, 45-6, 78 S. Ct. 99, 102 (1957). Dismissal can be based either on a lack of a cognizable legal theory or the absence of sufficient facts

alleged under a cognizable legal theory. *Balistreri v. Pacifica Police Dept.*, 901 F.2d 696, 699 (9th Cir. 1990); *Vines v. City of Dallas, Texas*, 851 F. Supp. 254, 259 (N.D. Tex. 1994).

In determining whether a dismissal is warranted pursuant to Rule 12(b)(6), the Court accepts as true all allegations contained in the plaintiff's complaint. *Gargiul v. Tompkins*, 704 F.2d 661, 663 (2d Cir. 1983), *vacated on other grounds*, 465 U.S. 1016, 104 S. Ct. 1263 (1984); *Kaiser Aluminum & Chem. Sales, Inc. v. Avondale Shipyards, Inc.*, 677 F.2d 1045, 1050 (5th Cir. 1982). In addition, all reasonable inferences are to be drawn in favor of the plaintiff's claims. *Kaiser Aluminum*, 677 F.2d at 1050. "To qualify for dismissal under Rule 12(b)(6), a complaint must on its face show a bar to relief." *Clark*, 794 F.2d at 970.

If the court, in its discretion, accepts for consideration matters that are beyond the pleadings then the motion to dismiss is converted into a motion for summary judgment under Rule 12(b). Rule 12(b) states, in pertinent part, that:

> [i]f, on a motion asserting the defense numbered (6) to dismiss for failure of the pleading to state a claim upon which relief can be granted, matters outside the pleading are presented to and not excluded by the court, the motion shall be treated as one for summary judgment and disposed of as provided in Rule 56 . . . .

FED. R. CIV. P. 12(b). A court is more likely to consider matters outside the pleadings if the "'extra-leading material is comprehensive and will enable a rational determination of a summary judgment motion[.]'" *Isquith ex rel. Isquith v. Middle South Utilities, Inc.*, 847 F.2d 186, 193 n.3 (5th Cir. 1988) (quoting 5 C. WRIGHT & A. MILLER, FEDERAL PRACTICE AND PROCEDURE § 1366 (1969)). However, the Court is unlikely to do so when it is scanty, incomplete, or inconclusive. *Id.*

The court must give all parties notice of such a conversion and provide them with an opportunity both to be heard and to present further materials in support of their positions on the motion. *Nowlin v. Resolution Trust Corp.*, 33 F.3d 498, 504 (5th Cir. 1994). Following conversion, the court should permit the parties to engage in discovery as appropriate before ruling on the converted motion. *Washington v. Allstate Ins. Co.*, 901 F.2d 1281 (5th Cir. 1990).

In this case, having received for consideration matters that are beyond the pleadings of the parties such as affidavits, contracts for health benefit plans, and statistical data, the Court will convert Defendants' motion to dismiss into a motion for summary judgment. Given that Plaintiffs subsequently filed a motion for summary judgment on the same issues, Plaintiffs have received ample notice that the case may be decided at this stage on the merits. Furthermore, at the motions hearing held on April 24, 1998, the Court informed the parties of its intention to convert Defendants' motion into a motion for summary judgment. The parties also

had an additional opportunity to be heard at the hearing and to present any additional evidence. Thus, both parties had sufficient notice of the conversion.

III. Summary Judgment Standard

Summary judgment is appropriate if no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law. FED. R. CIV. P. 56. A fact is "material" if its resolution in favor of one party might affect the outcome of the suit under governing law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247, 106 S. Ct. 2505, 2510 (1986). An issue is "genuine" if the evidence is sufficient for a reasonable jury to return a verdict for the nonmoving party. *Id.* If the evidence rebutting the motion for summary judgment is only colorable or not significantly probative, summary judgment should be granted. *Id.* at 249-50, 106 S. Ct. at 2511; *see Lewis v. Glendel Drilling Co.*, 898 F.2d 1083, 1088 (5th Cir. 1990).

Under Rule 56(c) of the Federal Rules of Civil Procedure, the moving party bears the initial burden of informing the district court of the basis for its belief that there is an absence of a genuine issue for trial and for identifying those portions of the record that demonstrate such absence. *Matsushita Elec. Ind. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586-87, 106 S. Ct. 1348, 1355-56 (1986); *Leonard v. Dixie Well Serv. & Supply, Inc.*, 828 F.2d 291, 294 (5th Cir. 1987).

Where the moving party has met its Rule 56(c) burden, the nonmovant "must do more than simply show that there is some metaphysical doubt as to the material facts . . . [T]he nonmoving party must come forward with 'specific facts showing that there is a *genuine issue for trial*.'" *Matsushita*, 475 U.S. at 586-87, 106 S. Ct. at 1356 (quoting FED. R. CIV. P. 56(e)) (emphasis in original); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23, 106 S. Ct. 2548, 2552 (1986); *Leonard*, 828 F.2d at 294. To sustain the burden, the nonmoving party must produce evidence admissible at trial. *Anderson*, 477 U.S. at 255, 106 S. Ct. at 2514; *Thomas v. Price*, 975 F.2d 231, 235 (5th Cir. 1992) ("To avoid a summary judgment, the nonmoving party must adduce admissible evidence which creates a fact issue. . . .").

IV. Improper Parties

Defendants argue that the Department and Bomer are improper parties to this suit. (Defendants' Motion, Instrument No. 10 at 10; Defendants' Reply, Instrument No. 24 at 10). First, Defendants contend that the Eleventh Amendment bars suit against both parties. The Eleventh Amendment provides that "[t]he judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by citizens of another state or by citizens or subject of any foreign state." U.S. CONST. amend. XI. In addition, the Eleventh Amendment "bars suit against a state entity . . . regardless of whether money damages or injunctive relief is sought. In determining whether an entity is entitled to . . . immunity, [the court] . . . 'must examine the particular entity in question and

its powers and characteristics as created by state law. . . .'" *Voisin's Oyster House, Inc. v. Guidry*, 799 F.2d 183, 186 (5th Cir. 1986) (quoting *Laje v. R.E. Thomason Gen. Hosp.*, 665 F.2d 724, 272 (5th Cir. 1982)).

Several factors are considered in determining whether an agency is an arm of the state including: (1) whether state statutes and case law view the agency as an arm of the state; (2) the source of the entity's funding; (3) whether the entity is concerned with local or statewide problems; (4) the degree of the agency's authority which is independent from the state; (5) whether the entity can sue and be sued in its own name; and (6) whether it has the right to hold and use property. *Guidry*, 799 F.2d at 186-87. "Positive answers to the latter two inquiries mitigate against an entity's being an alter ego of the State and thus against Eleventh Amendment immunity." *Correa v. City of Bay City*, 981 F. Supp. 477, 479 (S.D. Tex. 1997).

The Department is clearly a state agency, created by the laws of the state of Texas. *See* TEX. INS. CODE ANN. art. 1.01 *et. seq.* (West 1998); *El Paso Elec. Co. v. Texas Dep't of Ins.*, 937 S.W.2d 432, 434 (Tex. 1996). Its primary responsibility is "to regulate the business of insurance in this state." TEX. INS. CODE ANN. art. 1.01A (West 1998). The Department is in the executive branch of the state government, and is controlled by an executive officer, the Commissioner, who is appointed by the Department with the advice and consent of the Senate of Texas. *Id.* art. 1.09. Several members of the Department, such as deputies, assistants, and other personnel, are appointed by the Commissioner. *Id.* art.

1.02. All of the above factors favor a finding that the Department is an arm of the State of Texas and therefore entitled to Eleventh Amendment immunity. *See Correa*, 981 F. Supp. at 479. Consequently, the Court **DISMISSES** the Department from this lawsuit.

With respect to state officials, "'a gaping hole in the shield of sovereign immunity created by the [E]leventh [A]mendment and the Supreme Court' is the doctrine" of *Ex Parte Young*, 209 U.S. 123, 28 S. Ct. 441 (1908). *Saltz v. Tennessee Dep't of Employment Sec.*, 976 F.2d 966, 968 (5th Cir. 1992) (quoting *Brennan v. Stewart*, 834 F.2d 1248, 1252 (1988)). Under the *Ex Parte Young* doctrine, "a federal court, consistent with the Eleventh Amendment, may enjoin state officials to conform their future conduct to the requirements of federal law, even though such an injunction may have an ancillary effect on the state treasury." *Quern v. Jordan*, 440 U.S. 332, 337, 99 S. Ct. 1139, 1143 (1979). "The essential ingredients of the *Ex Parte Young* doctrine are that a suit must be brought against individual persons in their official capacities as agents of the state and the relief sought must be declaratory or injunctive in nature and prospective in effect." *Saltz*, 976 F.2d at 968 (footnote omitted); *see also Cigna Healthplan of La. v. Louisiana*, 82 F.3d 642, 644 n.1 (5th Cir. 1996) (recognizing "the federal courts have jurisdiction to hear suits against state officials where, as here, the plaintiffs seek only prospective declaratory or injunctive relief to prevent a continuing violation of federal law").

In this case, Plaintiffs have sued Bomer in his official capacity and also seek prospective injunctive relief, not

monetary damages. Therefore, Defendants' argument that suit against Bomer is barred by the Eleventh Amendment fails.

Second, Defendants argue that "[t]here may be a real question whether Commissioner Bomer is a proper party" based on the Plaintiffs' allegations in their complaint. (Defendants' Brief, Instrument No. 11 at 38 n.37). According to Defendants, Plaintiffs' "only allegation . . . [regarding Bomer's] official administrative capacity . . . [concerns] his responsibility for enforcing state insurance law. The only role for the Commissioner in Senate Bill 386 is to approve IROs (independent review organization) and it is very unclear whether . . . [Plaintiffs are] alleging [that] the IRO procedures are preempted." (*Id.* at 38 n.37). In response, Plaintiffs maintain that Bomer is a proper party to this suit because as the Commissioner, Bomer "is responsible for ensuring compliance with . . . the establishment and supervision of independent review organizations." (Plaintiffs' Motion, Instrument No. 20 at 5). The Court agrees with Plaintiffs' contention.

Clearly, Plaintiffs contest the inclusion of the IRO provisions in the Act. In particular, Plaintiffs state that the "IRO procedure improperly affects the administration of employee benefit plans, and is therefore an unwarranted extension into an area governed by ERISA. . . . As such, either directly or indirectly, HMOs and PPOs will incur costs in connection with the establishment of IROs under the Act, thereby also supporting a finding of preemption." (Plaintiffs' Motion, Instrument No. 20 at 17 n.17). Plaintiffs elaborated on this position at the hearing held on April 24, 1998.

(Transcript, Instrument No. 60 at 21). Furthermore, Defendants concede that Bomer, as the Commissioner, is responsible for approving the IRO procedure. (Defendants' Brief, Instrument No. 11 at 38 n.37).

Moreover, Defendants do not provide the Court with any authority for their proposition that Bomer is an improper party to this suit. On the contrary, the Commissioner of the Texas Board of Insurance has been named as a defendant in other cases similar to the instant case. *See NGS Am., Inc. v. Barnes*, 998 F.2d 296 (5th Cir. 1993) (enjoining the Commissioner of Insurance for the state of Texas from enforcing a Texas statute that was preempted by ERISA); *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir. 1991) (holding that the Texas Administrative Services Tax Act was preempted by ERISA and enjoining the Commissioner of Insurance from collecting the tax); *Texas Commerce Bancshares, Inc. v. Barnes*, 798 F. Supp. 1286 (W.D. Tex. 1992) (examining plaintiff's award of attorney fees and costs in ERISA preemption action filed against the Commissioner of Insurance). Consequently, given Bomer's role with the IRO procedure and other cases where the Commissioner has been named as a defendant, the Court finds that Bomer is a proper party to this suit.

V. Insurance Savings Clause

Plaintiffs claim that the Act is preempted by ERISA. Thus, as an initial matter, the Court will examine whether the Act is saved from preemption by ERISA's insurance savings clause.

ERISA provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates *insurance*, banking or securities." 29 U.S.C.A. § 1144(b)(2)(a) (West 1985) (emphasis added). The Supreme Court "delineated the requirements that a state statute must meet in order to come within the insurance facet of the savings clause" in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 741-47, 105 S. Ct. 2380, 2389-93 (1985). The Supreme Court in *Metropolitan Life* took the following conjunctive two-step approach:

> First, the [C]ourt determined whether the statute in question fitted the common sense definition of insurance regulation. Second, it looked at three factors: (1) [w]hether the practice (the statute) has the effect of spreading policyholders' risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry. If the statute fitted the common sense definition of insurance regulation *and* the court answered "yes" to *each* of the questions in the three part test, then the statute fell within the savings clause exempting it from ERISA preemption.

Tingle v. Pacific Mut. Ins. Co., 996 F.2d 105, 107 (5th Cir. 1993) (footnote omitted) (emphasis added). Therefore, "if a statute fails either to fit the common sense definition of insurance regulation or to satisfy any one element of the three-factor *Metropolitan Life* test, then the statute is not exempt

from preemption by the ERISA insurance savings clause." *Cigna*, 82 F.3d at 650.

When the Court begins to apply this test to the Act, it can both start and finish its analysis with the third factor of the *Metropolitan Life* test: on its face, the Act is obviously not "limited to entities within the insurance industry." Even though the Act lists health insurance carriers as one group covered by its terms, it also specifies that it applies to health maintenance organizations or other managed care entities for a health care plan. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West 1998). As the Act fails to meet the third factor of the *Metropolitan Life* test, the Court finds that the statute is not saved from preemption by the insurance exception of Section 514(b) of ERISA. *See Cigna*, 82 F.3d at 650 (holding that Louisiana's Any Willing Provider statute was not exempt from preemption by ERISA's savings clause because the statute was not limited to entities within the insurance industry).

VI. ERISA Preemption

Having determined that the Act is not saved by the insurance savings clause, the Court must next examine whether the Act is preempted by Section 514(a) of ERISA.

Section 514(a) governs the preemption of state laws by ERISA. More specifically, Section 514(a) provides that ERISA "shall supersede any and all State laws insofar as they . . . *relate to any employee benefit plan* . . . ." 29 U.S.C.A. § 1144(a) (West 1985) (emphasis added). Under ERISA

preemption analysis, a state law relates to an ERISA plan if it has a connection with or reference to such a plan. *Cigna*, 82 F.3d at 647.

If the Court determines that certain portions of a state statute are preempted by ERISA and therefore, contravene federal law, then the Court may sever those portions from the statute provided that their invalidity does not affect the remainder of the statute. *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 105 F.3d 1035, 1039 (5th Cir. 1997). The Court's decision to sever a statute is also based on whether or not that state statute has a provision for severability or nonseverability. *Id.*

Since pre-emption turns on Congress's intent, the court must begin "with the text of the provision in question, and move on, as need be, to the structure and purpose of the Act in which it occurs." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655, 115 S. Ct. 1671, 1676 (1995). "A facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid." *U.S. v. Salerno*, 481 U.S. 739, 745, 107 S. Ct. 2095, 2100 (1987). Thus, in this case, the Court must determine whether any claims brought under the Act would relate to an employee benefit plan and would, therefore, be preempted by Section 514(a) of ERISA.

A. What is an ERISA Plan?

First, the Court must examine what constitutes an ERISA plan. An employee welfare benefit plan (which includes health benefits plans), is defined as:

> any *plan, fund, or program* which was heretofore or is hereafter *established or maintained by an employer or by an employee organization, or by both* to the extent that such plan, fund, or program was established or is maintained *for the purpose of providing for its participants or their beneficiaries*, through the purchase of insurance or otherwise, (A) *medical, surgical, or hospital care or benefits*, or benefits in the event of sickness, accident, disability . . .

29 U.S.C.A. § 1002(1) (West Supp. 1998) (emphasis added). The first phrase—plan, fund, or program—has been interpreted as requiring an "ongoing administrative program" on the part of the employer. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11, 107 S. Ct. 2211, 2217 (1987). A "plan, fund, or program" under ERISA is established if "from the surrounding circumstances a reasonable person can ascertain the intended benefits, class of beneficiaries, the source of financing, and the procedures for receiving benefits." *Donovan v. Dillingham*, 688 F.2d 1367, 1371, 1373 (11th Cir. 1982); *see Peckham v. Gem State Mut. of Utah*, 964 F.2d 1043, 1047-48 (7th Cir. 1992). The administrative program, however, need not be elaborate. *Peckham*, 964 F.2d at 1048.

The second phrase of the definition—established or maintained by an employer—

> is designed to distinguish situations in which the employer merely acts as a conduit for the marketing of an insurance policy to individual employees (in which case no ERISA plan exists), from the situation in which the employer financially pays for some or all of the plan and/or otherwise is involved in its administration (e.g. defining and administering employee eligibility, or listing the plan as a benefit of employment).

RAND ROSENBLATT, LAW AND THE AMERICAN HEALTH CARE SYSTEM 190 (Supp. 1998). In particular, this second phrase is designed to "ensure that the plan is part of an employment relationship. . . . [This] requirement seeks to ascertain whether the plan is part of an employment relationship by looking at the degree of participation by the employer in the establishment or maintenance of the plan." *Peckham*, 964 F.2d at 1049.

In *Meredith v. Time Ins. Co.*, 980 F.2d 352, 355 (5th Cir. 1993), the Fifth Circuit outlined its "comprehensive test for determining whether a particular plan qualifies as an 'employee welfare benefit plan'" under ERISA. Under *Meredith*, the test requires the full analysis of

> whether a plan: (1) exists; (2) falls within the safe-harbor provision established by the Department of Labor; and (3) satisfies the primary elements of an

> ERISA "employee benefit plan"—establishment or maintenance by an employer intending to benefit employees. If any part of the inquiry is answered in the negative, the submission is not an ERISA plan. . . . [The Court's] analysis is informed by reference to ERISA itself, including germane indications of congressional intent, and to the extent Congress has failed to state its intention on the precise issue in question, we refer to permissible interpretations by the agency charged with administering the statute—the Department of Labor.

Id. Furthermore, ERISA does not regulate "bare purchases of health insurance where . . . the purchasing employer neither directly or indirectly owns, controls, administers or assumes responsibility for the policy or its benefits." *Taggert Corp. v. Life & Health Benefits Admin., Inc.*, 617 F.2d 1208, 1211 (5th Cir. 1980). Thus, in this case, the Court must determine whether the provisions of the Act relate to any employee benefit plan as defined by *Meredith*.

In this case, Defendants make the following argument:

> [Plaintiff] AEtna blurs the distinction between an ERISA plan (established by an employer to provide benefits to an employee) and a health plan (established by health insurance entities as a vehicle for bearing the risks of health insurance and providing coverage to an ERISA plan for those employees). AEtna admits plaintiffs 'offer products in the form of managed health care coverage to employees who are enrolled in

> ERISA and FEHBA plans in Texas.' AEtna may operate as a 'health plan,' but AEtna is not an ERISA plan established by an employer.

(Defendants' Reply, Instrument No. 24 at 1). In essence, Defendants argue that Plaintiffs are operating health plans, but that they are not operating ERISA plans that would be preempted by ERISA. The Court agrees.

The Act expressly regulates health insurance carriers, health maintenance organizations and managed care entities by specifically addressing their health plans and not the ERISA plans of employers. Under the Act, "[a] health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care." TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West 1998). A health insurance carrier "means an authorized insurance company that issues policies of accident and sickness" under Article 3.70-1 of the Texas Insurance Code. TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(6) (West 1998). A health maintenance organization includes "organization[s] licensed under the Texas Health Maintenance Organization Act[.]" *Id.* § 88.001(7). A managed care entity under the Act is defined as

> any entity which delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility,

> utilization, or costs and prices of such services to a defined enrollee population, *but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer* or a pharmacy licensed by the State Board of Pharmacy.

Id. § 88.001(8) (emphasis added).

The health plans provided by health insurance carriers, health maintenance organizations, or managed care entities, as previously defined, and the health care entities themselves cannot constitute ERISA plans because the third inquiry under the Fifth Circuit's test—whether the plan satisfies the primary elements of an ERISA "employee benefit plan"— must be answered in the negative. Plaintiffs admit that they "offer products in the form of managed health care coverage to employees who are enrolled in ERISA and FEHBA plans in Texas." (Plaintiffs' Motion, Instrument No. 20 at 3). Plaintiffs and the coverage provided by them, however, are not established or maintained by an employer.

Plaintiffs concede that they fall "within the term 'managed care entity' as defined in the Act[.]" (*Id.* at 4). A managed care entity does not include "an employer purchasing coverage or acting on behalf of its employees[.]" TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(8) (West 1998). Therefore, by definition, Plaintiffs and the managed health care plans that Plaintiffs offer would not satisfy the primary elements of an ERISA employee benefit plan because they are

not established or maintained by an employer. Rather, Plaintiffs are medical service providers to ERISA plans and their members.[2] Plaintiffs operate health plans rather than ERISA employee benefit plans. Consequently, the Court finds that Plaintiffs and the particular arrangement or services provided by them, that are addressed under the Act, are not ERISA employee benefit plans since the coverage is not established or maintained by an employer. *See Cigna*, 82 F.3d at 648 (recognizing that Plaintiffs, an HMO and a health insurer, were not ERISA plans); *Washington Physicians Serv. Ass'n v. Gregoire*, No. 97-35536, 1998 WL 318759, *3 (9th Cir. 1998) (stating that the statute makes it clear that the term "health plans" "refers to the plan offered by the health carrier (e.g., an HMO), not the benefit plan offered by the employer"); *Dukes v. U.S. Healthcare*, 57 F.3d 350, 356 (3d Cir. 1995) (noting the Department of Labor's argument that plaintiff's claims merely attacked "the behavior of an entity completely external to the ERISA plan[,] [the HMO]").

Nonetheless, Plaintiffs argue that the fact that Aetna is not an ERISA health plan is of "no significance to the preemption analysis." (Plaintiffs' Surreply, Instrument No. 33 at 1). Plaintiffs rely on *Cigna Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642 (5th Cir. 1996), for this argument.

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[2]At the hearing held on April 24, 1998, Mr. John B. Shely, counsel for Plaintiffs, argued that Plaintiffs "provide various services to employee benefit plans that are ERISA plans." (Transcript, Instrument No. 60 at 6).

In *Cigna*, CIGNA Healthplan of Louisiana ("CIGNA"), a licensed HMO, and Connecticut General Life Insurance Company ("CGLIC"), a licensed health insurer, filed suit against Richard Ieyoub, the Attorney General of the state of Louisiana, seeking a declaratory judgment that Louisiana's Any Willing Provider statute was preempted by ERISA. 82 F.3d at 644. "The Any Willing Provider statute . . . mandate[d] that '[n]o licensed provider . . . who agree[d] to the terms and conditions of the preferred provider contract . . . [could] be denied the right to become a preferred provider.'" *Id.* at 645 (quoting LA. REV. STAT. ANN. § 40:2202(5)(c) (West 1992)). The Fifth Circuit concluded that the statute was preempted by ERISA both because it referred to ERISA-qualified plans by including certain enumerated entities, and because it had a connection with such plans by mandating that "certain benefits available to ERISA plans . . . be construed in a particular manner." *Id.* at 648-49.

Since the Court found that the statute in *Cigna* directly affected benefits provided under the plan, the Court did not have to examine whether or not CIGNA or CGLIC was an ERISA plan. Rather, the Court based its decision on the substantial effect that the statute had on all insured plans. *Id.* at 648. The Court, however, did remark that the fact that CIGNA and CGLIC were not themselves ERISA plans was inconsequential. *Id.* at 648. It made this statement while discussing the statute's "connection with" ERISA plans. *Id.* The Court further explained that CIGNA's and CGLIC's status was inconsequential because:

> [b]y denying insurers, employer, and HMOs the right to structure their benefits in a particular manner, the statute [wa]s effectively requiring ERISA plans to purchase benefits of a particular structure when they contract with organizations like CIGNA and CGLIC. In that regard, the statute "b[ore] indirectly but substantially on all insured plans" and [wa]s accordingly preempted by ERISA.

Id. at 648-49 (quoting *Metropolitan Life*, 471 U.S. at 739, 105 S. Ct. at 2389).

In accordance with *Cigna*, the Court finds that whether or not Plaintiffs in this case are ERISA plans is inconsequential because, under current Fifth Circuit law, certain severable provisions of the Act, as discussed below, "relate to" ERISA employee benefit plans.

B. "Relates To" Analysis

A state law relates to an ERISA plan "in the normal sense of the phrase if it has a *connection with or reference to* such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S. Ct. 2890, 2899-2900 (1983) (emphasis added). The Supreme Court has given the phrase "relates to" a "broad common-sense meaning." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47, 107 S. Ct. 1549, 1553 (1987)). Under this definition,

> A state law can relate to an ERISA plan even if that law was not specifically designed to affect such plans,

> and even if its effect is only indirect. If a state law does not expressly concern employee benefit plans, it will be preempted insofar as it applies to benefit plans in particular cases. . . .

Cigna, 82 F.3d at 647. "The most obvious class of pre-empted state laws are those that are specifically designed to affect ERISA-governed employee benefits plans." *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1328 (5th Cir. 1992).

In determining whether a state law "relate[s] to" an ERISA plan, the Supreme Court has adopted a pragmatic approach. *See Travelers*, 514 U.S. 645 at 654-57, 115 S. Ct. at 1676-77. In *Travelers*, the Court stated that it "must go beyond the unhelpful text [of Section 514(a)] and the frustrating difficulty of defining its key term ['relates to'], and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive [preemption]." 514 U.S. at 656, 115 S. Ct. at 1677.

As stated by the Court in *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, in passing Section 514,

> Congress intended 'to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burdens of complying with conflicting directives among States or between States

> and the Federal Government . . ., [and to prevent] the potential for conflict in substantive law...
>
> requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.'

514 U.S. at 656, 115 S. Ct. at 1677 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142, 111 S. Ct. 478, 484 (1990)). Therefore, "[t]he basic thrust of . . . [ERISA's] pre-emption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657, 115 S. Ct. at 1677-78.

Although the text of Section 514(a) is clearly expansive, in so far as it affects all state laws that relate to ERISA plans, the phrase "relate[s] to" does not "extend to the furthest stretch of its indeterminacy[.]" *Id.* at 655, 115 S. Ct. at 1677. If that were the case, "then for all practical purposes pre-emption would never run its course" and courts would be required "to read Congress's words of limitation as mere sham, and to read the presumption against preemption out of the law whenever Congress speaks to the matter with generality." *Id.* Thus, in particular, ERISA's "relate[s] to" language was not "intended to modify 'the starting presumption that Congress does not intend to supplant state law'" which falls within areas of traditional state regulation. *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, —, 117 S. Ct. 1747, 1751-52 (1997) (quoting *Travelers*, 514 U.S. at 654-55, 115 S. Ct. at 1676).

"The historic powers of the State include the regulation of matters of health and safety." *De Buono*, 520 U.S. at —, 117 S. Ct. at 1751-52 (citing *Hillsborough County v. Automated Med. Lab., Inc.*, 471 U.S. 707, 716, 105 S. Ct. 2371, 2376 (1985)). The Act, in this case, regulates the medical decisions of health insurance carriers, health maintenance organizations, and other managed care entities, *see* TEX. CIV. PRAC & REM CODE ANN. § 88.002 (West 1998), and therefore, clearly operates in a field that has been traditionally occupied by the States. "[W]here federal law is said to bar state action in fields of traditional state regulation," this Court should work on the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 654-55, 115 S. Ct. at 1676 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230, 67 S. Ct. 1146, 1152 (1947)). Consequently, Plaintiffs "bear the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law.'" *De Buono*, 520 U.S. at —, 117 S. Ct. at 1752.

1. "Reference To"

Under the "reference to" inquiry, the Supreme Court has "held preempted a law that 'impos[ed] requirements by reference to [ERISA] covered programs,' . . . a law that specifically exempted ERISA plans from an otherwise generally applicable garnishment provision, . . . and a common-law cause of action premised on the existence of an ERISA plan." *California Div. of Labor Standards Enforcement, N.A., Inc. v. Dillingham Constr.*, 519 U.S. 316,

—, 117 S. Ct. 832, 837-38 (1997) (citations omitted) (quoting *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 131, 113 S. Ct. 580, 584 (1992)). Thus, "[w]here a State's law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation . . . that 'reference' will result in pre-emption." *Dillingham*, 519 U.S. at —, 117 S. Ct. at 838.

In *Travelers*, the Supreme Court examined New York statutes that imposed "surcharges on bills of patients whose commercial insurance coverage [wa]s purchased by employee health-care plans governed by ERISA and . . . on HMOs insofar as their membership fees . . . [were] paid by an ERISA plan." 514 U.S. at 649, 115 S. Ct. at 1673-74. Notably, the surcharge on HMOs was "not an increase in the rates to be paid by an HMO to a hospital, but a direct payment by the HMO to the State's general fund." *Id.* at 650, 115 S. Ct. at 1674. The Court held that the "surcharge statutes . . . [could not] be said to make 'reference to' ERISA plans in any manner" because the surcharges were "imposed upon patients and HMOs, regardless of whether the commercial coverage or membership, respectively, [wa]s ultimately secured by an ERISA plan, private purchase, or otherwise[.]" *Id.* at 656, 115 S. Ct. at 1677.

Similarly, in this case, the Act imposes a standard of ordinary care directly upon health insurance carriers and health maintenance organizations when making health care treatment decisions, regardless of whether the commercial coverage or membership therein is ultimately secured by an ERISA plan.

See TEX. CIV. PRAC. & REM. CODE § 88.001-88.002 (West 1998). The Act also requires managed care entities to exercise ordinary care when making medical decisions. *Id.* § 88.002(a). However, as already mentioned, the Act specifically excludes ERISA plans from the definition of a "managed care entity." *See id.* § 88.001(8). Section 88.001(8) of the Texas Civil Practice and Remedies Code, as added by the Act, provides that a "managed care entity" does not include "an employer purchasing coverage or acting on behalf of its employees." *Id.* Consequently, as in *Travelers*, the Act cannot be said to make any reference to ERISA plans.

Plaintiffs, however, maintain that preemption is mandated because the Act has an express reference to ERISA plans in several other provisions. (Plaintiffs' Motion, Instrument No. 20 at 7). In particular, Plaintiffs seem to argue that the mere inclusion of certain terms that allegedly refer to ERISA plans, such as "plan," "health care plan," "health maintenance organization," and "managed care entity," warrants preemption. (Plaintiffs' Motion, Instrument No. 20 at 7-9). Plaintiffs rely on *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 113 S. Ct. 580 (1992), and *Cigna* for this proposition.[3]

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[3]Plaintiffs also claim that the Fifth Circuit's opinion in *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 105 F.3d 1035 (5th Cir. 1997), mandates a finding that the Act "refers to" ERISA plans. However, in *Texas Pharmacy*, the Court never discussed the "reference to" or "refers to" analysis. *See id.* at 1037. Rather, the Court simply concluded that the "Texas statute relate[d] to ERISA plans because it 'eliminate[d] the choice of one

In *Greater Washington*, 506 U.S. at 130, 113 S. Ct. at 583, the Supreme Court determined that "Section 2(c)(2) of the District's Equity Amendment Act specifically refer[red] to welfare benefit plans regulated by ERISA and on that basis alone [wa]s pre-empted." Section 2(c)(2) of the Equity Amendment Act provided the following: "Any employer who provides health insurance coverage for an employee shall provide health insurance equivalent to the *existing health insurance coverage* of the employee while the employee receives or is eligible to receive workers' compensation benefits under this chapter." *Id.* at 128, 113 S. Ct. at 582 (quoting D.C. CODE ANN. § 36-307(a-1)(1) (Supp. 1992) (emphasis added)). Furthermore, the employer had to provide this health insurance coverage for a maximum of 52 weeks "at the same benefit level that the employee had at the time the employee received or was eligible to receive workers' compensation benefits." *Id.* (quoting D.C. CODE ANN. § 36-307 (a-1) (3) (Supp. 1992)). Thus, the health insurance coverage required of employers was "measured by *reference*

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method of structuring benefits,' by prohibiting plans from contracting with pharmacy networks that exclude any willing provider." *Id.* Thus, the Court found that Texas's Any Willing Provider statute had a "connection with" ERISA plans. *Id.*

The Court also mentioned that the statute applied to ERISA benefits plans themselves because it defined "managed care providers to include HMOs, PPOs or 'another organization' that provide[d] health care benefits." *Id.* at 1038. Notably, the Court emphasized the phrase "another organization" as the entity that could conceivably constitute an ERISA plan. *Id.*

to 'the existing health insurance coverage' provided by the employer" and had to be maintained at the same benefit level. *Id.* at 130, 113 S. Ct. at 583-84 (emphasis added) (quoting D.C. CODE ANN. § 36-307(a-1)(1) and (3) (Supp. 1992)).

The Court then determined that "[t]he employee's 'existing health insurance coverage,' in turn, [wa]s a welfare benefit plan under ERISA . . . because it involv[ed] a fund or program maintained by an employer for the purpose of providing health benefits for the employee 'through the purchase of insurance or otherwise.'" *Id.* at 130, 113 S. Ct. at 584 (quoting 29 U.S.C. § 1002(1)). Thus, since the Equity Amendment Act imposed requirements by *reference to* such employer-sponsored health insurance programs that were subject to ERISA regulation, the Court concluded that the Act was preempted by ERISA. *Id.* at 130-31, 113 S. Ct. at 584.

Contrary to Plaintiffs' contention, in *Greater Washington*, the Supreme Court did not conclude that the statute referred to ERISA plans simply because it contained certain terminology. Rather, as explained in *California Div. of Labor Standards Enforcement, N.A., Inc. v. Dillingham Constr.*, 519 U.S. at —, 117 S. Ct. at 838, the Court reasoned that the reference to ERISA plans resulted in preemption because the existence of ERISA plans was essential to the statute's operation.[4] Unlike the statute in *Greater*

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[4]The Supreme Court reached the same conclusion in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S. Ct. 478 (1990). In *Ingersoll-Rand*, the Court held that a Texas wrongful discharge claim made "specific *reference to*, and indeed [wa]s premised on,

Washington, the Act is not premised on the existence of an ERISA plan. It merely requires health insurance carriers, HMOs, and other managed care entities to exercise ordinary care when making medical decisions. The Act imposes this standard on these entities without any reference to or reliance on an ERISA plan.

In *Cigna*, 82 F.3d at 645-47, the Fifth Circuit held that Louisiana's Any Willing Provider statute was preempted by ERISA because it referred to ERISA-qualified plans. The statute required all licensed providers "who agre[ed] to the terms and conditions of the *preferred provider contract*" to be accepted as providers in the preferred provider organization ("PPO"). LA. REV. STAT. ANN. § 40:2202(5)(C) (West 1992) (emphasis added). Under the Health Care Cost Control Act, a "preferred provider contract" was defined as "an agreement 'between a provider or providers and a *group purchaser* or purchasers to provide for alternative rates of payment specified in advance for a defined period of time.'" *Cigna*, 82 F.3d at 647-48 (quoting LA. REV. STAT. ANN. § 40:2022(5)(a) (emphasis added)).

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the existence of a pension plan." *Id.* at 140, 111 S. Ct. at 483 (emphasis added). In order to prevail on this wrongful discharge claim, plaintiff had to plead and the court had to find "that an ERISA plan exist[ed] and the employer had a pension-defeating motive in terminating the employment." *Id.* Therefore, since the Court's inquiry had to be "directed to the [ERISA] plan," the Court found that the cause of action "relat[ed] to" an ERISA plan. *Id.*

The Fifth Circuit then examined the definition of "group purchasers." Under the statute, group purchasers may have included entities "such as 'Taft-Hartley trusts or employers who establish or participate in self funded trusts or programs,' which '*contract [with health care providers] for the benefit of their . . . employees.*'" *Cigna*, 82 F.2d at 648 (quoting LA. REV. STAT. ANN. § 40:2022(5)(a) (emphasis added)). Since the entities encompassed by the term "group purchasers" included ERISA plans, the Court determined that Louisiana's Health Care Cost Control Act, "and through it the Any Willing Provider statute, expressly refer[red] to ERISA plans." *Id.*

Unlike the statute in *Cigna*, the requirement imposed by the Act does not contain a reference to ERISA plans. The Act states that health insurance carriers, HMOs, and other managed care entities have a duty to exercise ordinary care when making health care treatment decisions. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002 (West 1998). None of these enumerated entities constitute ERISA plans since, by definition, they are not "established or maintained by an employer or by an employee organization . . . for the purpose of providing" health care benefits for employees. 29 U.S.C.A. § 1002(1) (West Supp. 1998); *see* TEX. CIV. PRAC. & REM. CODE ANN. § 88.001 (West 1998).

In this case, the Court finds that, as in *Travelers*, the existence of an ERISA plan is not essential to the operation of the Act. Furthermore, the Act does not work "immediately and exclusively upon ERISA plans." *Dillingham*, 514 U.S. at —, 117 S. Ct. at 838. Consequently, the Court concludes that

the Act "cannot be said to make a 'reference to' ERISA plans in any manner." *Travelers*, 514 U.S. at 656, 115 S. Ct. at 1677.

Plaintiffs also suggest that the Act explicitly refers to ERISA plans by its use of the term "health care plan" and "managed care entity." (Plaintiff's Motion, Instrument No. 20 at 8). The Act defines "health care plan" as "any plan whereby a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services." TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(3) (West 1998). The Act then states that a "managed care entity for a *health care plan*" must exercise ordinary care when making medical decisions. *Id.* § 88.002(a) (emphasis added). The phrase "health care plan" cannot be isolated from the term "managed care entity" simply to create a reference to an ERISA plan. In this context, "health care plan" cannot constitute an ERISA plan because a "managed care entity . . . does not include an employer purchasing coverage or acting on behalf of its employees[.]" *Id.* § 88.001(8).

2. "Connection With"

"A law that does not refer to ERISA plans may yet be pre-empted if it has a 'connection with' ERISA plans." *Dillingham*, 519 U.S. at —, 117 S. Ct. at 838. "To determine whether a state law has the forbidden connection, [the court looks] . . . both to 'the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive,' as well as to the nature of the effect of the state law on ERISA plans." *Id.* (quoting *Travelers*, 514 U.S.

at 656, 115 S. Ct. at 1677); *see De Buono*, 520 U.S. at —, 117 S. Ct. at 1750 (noting the Court's rejection of a strictly literal reading of Section 514(a) and emphasis on the objectives of the ERISA statute).

Here, Plaintiffs contend that the Act has a "connection with" ERISA plans in several ways. Plaintiffs claim that the Act improperly imposes state law liability on ERISA entities, impermissibly mandates the structure of plan benefits and their administration, unlawfully binds plan administrators to particular choices, and wrongfully creates an alternate enforcement mechanism. (Plaintiffs' Motion, Instrument No. 20 at 9-18).

i. Imposition of State Law Liability

According to Plaintiffs, the "Fifth Circuit has twice held that attempts to impose state law liability on managed care entities in 'connection with' their 'health care treatment decisions' fall within the scope of the preemption clause." (Plaintiffs' Response, Instrument No. 20 at 10). In particular, Plaintiffs rely on the Fifth Circuit's decisions in *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), and *Rodriguez v. Pacificare of Tex., Inc.*, 980 F.2d 1014 (5th Cir. 1993) for this argument.

In *Corcoran*, 965 F.2d at 1331, the Fifth Circuit held that a Louisiana tort action for the wrongful death of an unborn child was preempted by ERISA. In that case, United HealthCare ("United"), the provider of utilization review

services[5] to an employee benefit plan, determined that Mrs. Corcoran's hospitalization during the final months of her pregnancy was not necessary despite her doctors' repeated recommendations for complete bed rest. *Id.* at 1322-24. The contract between United and Mrs. Corcoran's employer provided that United would "contact the Participant's physician and based upon the medical evidence and normative data determine whether the Participant should be eligible to receive full plan benefits for the recommended hospitalization and the duration of benefits." *Id.* at 1331 (quotation omitted). Contrary to her doctor's requests, United only authorized ten hours per day of home nursing care for Mrs. Corcoran. *Id.* at 1324.

While the nurse was off-duty, the fetus went into distress and died. *Id.* Subsequently, the Corcorans brought suit against United for wrongful death, alleging "that their unborn child died as a result of various acts of negligence committed by" the mother's health plan and United. *Id.* at 1324.

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[5]"Utilization review" is a form of cost-containment service that "refers to 'external evaluations that are based on established clinical criteria and are conducted by third-party payors, purchasers, or health care organizers to evaluate the appropriateness of an episode, or series of episodes, of medical care.'" *Corcoran*, 965 F.2d at 1323 (quoting Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 HOUS. L. REV. 191, 192-93 (1989)).

United argued that the Corcorans' claims were preempted by ERISA because its "decision [was] made in its capacity as a plan fiduciary [and was] about what benefits were authorized under the [p]lan." *Id.* at 1329. According to United, the company simply applied previously established eligibility criteria in order to determine whether Mrs. Corcoran was qualified for the benefits provided by the plan. *Id.* Thus, United maintained that, under prevailing ERISA preemption law, the Corcorans could not "sue in tort to redress injuries flowing from decisions about what benefits are to be paid under a plan." *Id.* at 1330.

The Corcorans, on the other hand, contended that their cause of action sought "to recover benefits solely for United's erroneous medical decision that Mrs. Corcoran did not require hospitalization during the last month of her pregnancy." *Id.* at 1330. Therefore, the Corcorans continued, United's exercise of medical judgment fell "outside the purview of ERISA preemption." *Id.*

Unable to agree with either characterization, the Fifth Circuit concluded that United made "medical decisions . . . in the context of making a determination about the availability of benefits under the plan." *Id.* at 1331. The Court reasoned that "United decide[d] 'what the medical plan . . . [would] pay for.' When United's actions [we]re viewed from this perspective, it . . . [became] apparent that the Corcorans [we]re attempting to recover for a tort allegedly committed in the course of handling a benefit determination." *Id.* at 1332 (quoting the Quality Care Program ("QCP") booklet which contains a description of the QCP, a cost-containment service

plan, and the services provided by United). Since United made the erroneous medical decision as a "part and parcel of its mandate to decide what benefits [we]re available under the . . . plan[,]" the Court concluded that ERISA's preemption of "state-law claims alleging improper handling of benefit claims [wa]s broad enough to cover the cause of action asserted here." *Id.* "Although imposing liability on United . . . [may] have the salutary effect of deterring poor quality medical decisions, . . . [the Court found there was] a significant risk that state liability rules would be applied differently to the conduct of utilization review companies in different states." *Id.* at 1333.

Despite its finding of preemption, the Court acknowledged "the fact that . . . [its] interpretation of the preemption clause . . . [left] a gap in remedies within a statute intended to protect participants in employee benefit plans" and suggested a reevaluation of ERISA. *Id.* at 1333, 1338-39. Indeed, the Fifth Circuit recognized that:

> [t]he result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake. This is troubling for several reasons. First, *it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system.* With liability rules generally inapplicable, there is theoretically less deterrence of substandard medical decision making. Moreover, if the cost of compliance with a standard of care . . . need not be factored into utilization review companies' cost of doing business,

bad medical judgments will end up being cost-free to the plans that rely on these companies to contain medical costs. ERISA plans, in turn, will have one less incentive to seek companies that can deliver both high quality services and reasonable prices.

Second, in any plan benefit determination, there is always some tension between the interest of the beneficiary in obtaining quality medical care and the interest of the plan in preserving the pool of funds available to compensate all beneficiaries. . . .

Finally, cost containment features such as the one at issue in this case did not exist when Congress passed ERISA. While we are confident that the result we have reached is faithful to Congress's intent neither to allow state-law causes of actions that related to employee benefit plans nor to provide beneficiaries in the Corcoran's position with a remedy under ERISA, the world of employee benefit plans has hardly remained static since 1974. *Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees. Our system, of course, allocates this task to Congress, not the courts, and we acknowledge our role today by interpreting ERISA in a manner consistent with the expressed intentions of its creators.*

Id. at 1338 (emphasis added).[6] Since *Corcoran*, the Supreme Court has reevaluated the "potentially infinite reach of 'relations' and 'connections'" under ERISA preemption and has rendered three decisions, namely *Travelers*, *Dillingham*, and *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 117 S. Ct. 1747 (1997), that "reveal the proper way to analyze[ ] ERISA preemption." *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60, 64-65 (D. Mass. 1997) (quoting *Travelers*, 514 U.S. at 656, 115 S. Ct. at 1677).[7]

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[6]The Fifth Circuit also requested further clarification from the Supreme Court and further legislative action from Congress in *Texas Pharmacy*, 105 F.3d at 1039-40. In *Texas Pharmacy*, the Court "conclude[d] that the result in that case [wa]s compelled by the unmistakable breadth of ERISA preemption recognized by the Supreme Court[.]" *Id.* at 1040. The Court, however, emphasized that "[a] different result . . . [would] require further guidance from the Supreme Court or further action from Congress." *Id.*

[7]Indeed, in light of the fundamental changes that have taken place in the health care delivery system, it may be that the Supreme Court has gone as far as it can go in addressing this area and it should be for Congress to further define what rights a patient has when he or she has been negatively affected by an HMO's decision to deny medical care. Congress has begun to examine the "cost containment" objectives of health plans, referenced in *Corcoran*, to determine whether their original intent to disallow state causes of action related to the denial of benefits is still reasonable. *See* Larry Lipman & Rebecca Carr, *Rival Bills Aim to Heal HMO Issues*, ATLANTA J. & ATLANTA CONST., July 17, 1998, at A1. "A House Republican task force outlined a bill that

Without the benefit of these recent opinions, the Court in *Corcoran* stated that "the fact that states traditionally have regulated in a particular area is no impediment to ERISA pre-emption." 965 F.2d at 1334. As such, the Court did not begin, as the recent Supreme Court cases did, with the presumption against preemption where the statute at issue addresses a historic police power of the states—namely, a

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seeks to give patients . . . an appeals process for managed care decisions . . . ." *Id.*

However, in a recent statement regarding H.R. 4250, the Patient Protection Act, Congressman Pete Sessions indicated the legislature's desire to have the judiciary define the scope of ERISA preemption. 144 CONG. REC. E1471-04 (daily ed. July 30, 1998) (speech of Representative Pete Sessions). Regrettably, Rep. Sessions sought to "ensure that the Patient Protection Act neither broaden[ed] nor change[d] the current scope of ERISA preemption as it [wa]s being developed in the courts." *Id.* at E1472. This statement clearly exemplifies the legislature's misunderstanding as to the role of the judiciary. The courts can neither narrow nor broaden the scope of ERISA preemption in a vacuum. Rather, the courts can only attempt to interpret the scope of the ERISA preemption clause, as enacted by Congress some 24 years ago, in light of the congressional intent. Defining the scope of ERISA preemption is a responsibility delegated to the legislative branch of government. Interpreting the legislative intent concerning the scope of ERISA preemption can only be accomplished by the courts after the legislature has done its job. If Congress wants the American citizens to have access to adequate health care, then Congress must accept its responsibility to define the scope of ERISA preemption and to enact legislation that will ensure every patient has access to that care.

matter of health and safety. *See Dillingham*, 519 U.S. at —, 117 S. Ct. at 838; *De Buono*, 520 U.S. at —, 117 S. Ct. at 1751-52; *Travelers*, 514 U.S. at 653-55, 115 S. Ct. at 1676-77. Instead, the Court in *Corcoran* reasoned that "Congress perhaps *could not have predicted* the interjection into the ERISA 'system' of the medical utilization review process[,]" and therefore, concluded that "Congress enacted a preemption clause so broad and a statute so comprehensive that it would be incompatible with the language, structure, and purpose of the statute to allow tort suits against entities so integrally connected with a plan." *Corcoran*, 965 F.2d at 1334 (emphasis added). Although the fact that "the States traditionally regulated . . . [certain] areas would not immunize their efforts[,]" since *Corcoran*, it is clear that there must be an "indication in ERISA . . . [or] its legislative history of any *intent on the part of Congress* to preempt" a traditionally state-regulated substantive law. *Dillingham*, 519 U.S. at —, 117 S. Ct. at 840-41 (emphasis added).

> Furthermore, in *Corcoran*, the Court noted that:
> [t]he cost of complying with varying substantive standards would increase the cost of providing utilization review services, thereby increasing the cost to health benefit plans of including cost containment features such as the Quality Care Program (or causing them to eliminate this sort of cost containment program altogether) and ultimately decreasing the pool of plan funds available to reimburse participants.

965 F.2d at 1333. However, the Supreme Court in *Travelers* emphasized that an "indirect economic influence . . . does not

bind a plan administrator to any particular choice and thus function as a regulation of an ERISA plan itself." 514 U.S. at 659, 115 S. Ct. at 1679. Moreover,

> if ERISA were concerned with any state action—such as quality of care standards or hospital workplace regulations—that increased the cost of providing certain benefits, and thereby, potentially affected the choices made by ERISA plans, [then] we could scarcely see the end of ERISA's pre-emptive reach, and the words 'relate to' would limit nothing.

Dillingham, 519 U.S. at —, 117 S. Ct. at 840 (citing *Travelers*, 514 U.S. at 663-64, 115 S. Ct. at 1681).

In light of the Supreme Court's recent mandate regarding ERISA preemption analysis, perhaps the Fifth Circuit would reach a different decision in *Corcoran* today. Even so, this Court finds the facts in *Corcoran* to be distinguishable from the conduct covered by the Act.

The plaintiffs in *Corcoran* filed suit against their HMO regarding a *medical decision made in relation to the denial of certain plan benefits*. In this case, a suit brought under the Act would relate to the *quality of benefits* received from a managed care entity when benefits are actually provided, not denied. The Act imposes a duty of ordinary care upon certain entities when making health care treatment decisions and holds those entities liable for damages proximately caused by a failure to exercise that duty. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West 1998). Furthermore, the Act clearly

states that a "health care treatment decision" is "a determination made when medical services are *actually provided* by the health care plan and a decision which affects the *quality* of the diagnosis, care, or treatment provided to the plan's insureds or enrollees." *Id.* § 88.001(5) (emphasis added). Thus, *Corcoran* is factually distinguishable from the instant case.[8]

The facts in *Rodriguez v. Pacificare of Tex., Inc.*, the other case cited by Plaintiffs for their argument that the Act wrongfully imposes state law liability on managed care entities, may be distinguished for the same reason. In *Rodriguez*, David Rodriguez ("Rodriguez") brought a negligence action against his HMO and his primary care physician. 980 F.2d at 1016. Rodriguez attempted to seek medical attention for himself and his children after they were

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[8]The Court in *Corcoran* recognized a similar distinction. The Court discussed *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990), a case in which the district court held that a malpractice action brought against an HMO was not preempted by ERISA, and acknowledged that the *Smith* case initially appeared to support the Corcorans' position since "the plaintiff was attempting to hold an ERISA entity liable for medical decisions." *Corcoran*, 965 F.2d at 1333 n.16. However, the Court distinguished the facts in *Smith* from the Corcorans' situation because "the medical decisions at issue . . . [in *Smith* did] not appear to have been made in connection with a cost containment feature of the plan or any other aspect of the plan which implicated the management of plan assets, but were instead made by a doctor in the course of treatment." *Id.*

involved in an automobile accident. *Id.* Rodriguez believed that he and his children needed to see an orthopedic surgeon, but he was unable to obtain the requisite referral letter from their primary care physician or his HMO. *Id.* Without obtaining the needed letter, Rodriguez and his family went to see an orthopedic surgeon who placed Rodriguez on a therapy program. *Id.* Rodriguez's HMO refused to cover the expenses because Rodriguez had not first obtained approval for such expenses as required by his plan. *Id.* Rodriguez thereafter filed suit against his HMO and primary care physician "for failing to 'provide prompt and adequate medical care and coverage.'" *Id.* (quoting Rodriguez's complaint filed in Texas state court).

The Fifth Circuit determined that Rodriguez's state law claims were sufficiently related to the employee benefit plan" because his "claims, at bottom, result[ed] from dissatisfaction over . . . [his HMO's] handling of his medical claim." *Id.* at 1017. Unlike Rodriguez's claims against his HMO and primary care physician, a suit brought under the Act may challenge the quality of benefits actually received without challenging a denial of benefits or the handling of a medical claim. A suit addressing the quality of care actually received is more akin to the claims asserted by plaintiffs in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995).[9]

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[9]As an additional argument, Defendants suggest that "AEtna is barred by res judicata from asserting ERISA preemption as a defense to the quality of care claims embodied in Senate Bill 386." (Defendants' Response, Instrument No. 46 at 19). According to Defendants, the *Dukes* case is "res judicata as to AEtna because

In *Dukes*, the Third Circuit examined two separate claims. The first claim involved the death of Darryl Dukes ("Dukes"). Dukes had several ailments which prompted him to visit his primary care physician who identified a problem with his ear. *Dukes*, 57 F.3d at 352. Later, another doctor performed surgery on Dukes's ear and ordered blood tests to

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AEtna is the successor in interest to the defendant in *Dukes*, U.S. Healthcare." (*Id.*). "As the successor in interest to U.S. Healthcare after *Dukes* was decided, [Defendants continue,] AEtna was in essence the HMO that lost in *Dukes*, wherein the court clearly limited and expressly distinguished the holding of *Corcoran* from cases in which the claims are based on the quality of care provided by the HMOs." (*Id.*).

The Fifth Circuit's "test for res judicata requires that: (1) The parties be identical in both suits, (2) A court of competent jurisdiction rendered the prior judgment, (3) There was a final judgment on the merits in the previous decision, and (4) The plaintiff raises the same cause of action or claim in both suits." *In re Howe*, 913 F.2d 1138, 1143-44 (5th Cir. 1990). In this case, Defendants' res judicata argument clearly fails to meet the fourth requirement. Plaintiffs seek a declaration that the Act is preempted by Section 514(a) of ERISA whereas, in *Dukes*, 57 F.3d at 351, U.S. Healthcare, Inc. sought a determination that removal of the plaintiffs' claims to federal court was proper under the complete preemption doctrine. Furthermore, in *Dukes*, the Third Circuit did not address whether the plaintiffs' state law claims were preempted under Section 514(a)—the exact issue in this case. *Id.* at 361. Rather, the Court left this issue open for resolution by the state courts on remand. *Id.* Consequently, the Court finds that Aetna is not by barred by res judicata from arguing that the Act is preempted by ERISA.

be performed. *Id.* For some unknown reason, when Dukes presented the prescription to the laboratory, the hospital refused to perform the blood tests. *Id.* On the next day, Dukes went to see a third doctor who also ordered blood tests. *Id.* The hospital performed the tests. *Id.* However, by that time, Dukes's condition had worsened and he subsequently died. At the time of his death, Dukes's blood sugar level was extremely high—a condition that allegedly could have been detected through a timely blood test. *Id.*

The other claim, examined in *Dukes*, concerned Ronald and Linda Visconti and their stillborn child. *Id.* at 353. The Viscontis maintained that Linda's obstetrician negligently ignored symptoms that Linda exhibited during the third trimester of her pregnancy that were typical of preeclampsia. *Id.*

"[T]he plaintiffs in these two cases filed suit in state court against health maintenance organizations ("HMOs") organized by U.S. Healthcare, Inc., claiming damages, under various theories, for injuries arising from the medical malpractice of the HMO-affiliated hospitals and medical personnel." *Id.* at 351. The defendant HMOs removed both cases to federal court based on the "complete preemption doctrine."[10] *Id.* at 351. The Court held that since plaintiffs'

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[10]The "complete preemption" exception provides that "Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64, 107 S. Ct. 1542, 1546 (1987). "The Supreme Court has

claims fell outside the scope of the ERISA provision granting the right to recover benefits and enforce rights due under terms of the plan or to clarify rights to future benefits then the complete preemption doctrine did not permit removal. *Id.* In particular, the Court held that "*[q]uality control of benefits*, such as health care benefits provided here, is a field traditionally occupied by state regulation. *Id.* at 357 (emphasis added) (citing *Travelers*, 514 U.S. at 657-59, 115 S. Ct. at 1678-79). The Court then "interpret[ed] the silence of Congress as reflecting an intent that it remain as such." *Id.*

This Court finds the discussion in *Dukes* to be applicable here.[11] The Court, in *Dukes*, made a distinction

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determined that Congress intended the complete-preemption doctrine to apply to state causes of action which fit within the scope of ERISA's civil-enforcement provisions." *Dukes*, 57 F.3d at 354 (quoting *Metropolitan Life*, 481 U.S. 64-66, 107 S. Ct. at 1547-48).

[11]Plaintiffs claim that this Court cannot rely on the discussion in *Dukes* because it is a removal case. (Plaintiffs' Motion, Instrument No. 20 at 31). The Court recognizes that a determination that a claim is not completely preempted under Section 502(a) of ERISA does not necessarily mean that that claim is not preempted under Section 514. *See Dukes*, 57 F.3d at 352 (holding that plaintiffs' claims are not completely preempted under Section 502, but remanding the case to the state court for a determination of whether plaintiffs' claims are preempted under Section 514(a)); *Rice v. Panchal*, 65 F.3d 637, 646 n.10 (7th Cir. 1995). However, the Court finds the Third Circuit's discussion of state regulation of "quality of care" to be quite relevant to the

between a claim for the withholding of benefits and a claim about the quality of benefits received. The Court reasoned that "[i]nstead of claiming that the welfare plans in any way withheld some quantum of plan benefits due, the plaintiffs in both cases complain[ed] about the *low quality of the medical treatment* that they *actually received* . . . ." *Id.* at 357 (emphasis added). In particular, "Dukes d[id] not allege . . . that the Germantown Hospital refused to perform blood studies on Darryl because the ERISA plan refused to pay for those studies. Similarly, the Viscontis d[id] not contend that Serena's death was due to their welfare plan's refusal to pay for or otherwise provide for medical services." *Id.* at 356-57. In this case, a suit may be brought under the Act that simply challenges the quality of the benefits received, not a benefit determination.

Also in *Dukes*, the Court distinguished the *Corcoran* case based on the dual roles that may be assumed by an HMO. *Dukes*, 57 F.3d at 360-61. The Court emphasized that in *Corcoran*, United "only performed an administrative function inherent in the 'utilization review'" whereas the defendant HMOs in *Dukes* played two roles—the utilization review role and the role as an arranger for the actual medical treatment for plan participants. *Id.* at 361. "[U]nlike *Corcoran*, [in *Dukes*] there . . . [was] no allegation . . . that the HMOs denied

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instant case.

Notably, despite their supposed opposition to removal cases, Plaintiffs also request this Court to rely heavily on two other removal cases, *Corcoran* and *Rodriguez*.

anyone any benefits that they were due under the plan. Instead, the plaintiffs [in *Dukes* were] . . . attempting to hold the HMOs liable for their role as the arrangers of their decedents' medical treatment." *Id.* Likewise, a plaintiff bringing suit under the Act may seek to hold a HMO liable in its position as the arranger of poor quality medical treatment, thereby, avoiding any allegation that the HMO wrongfully denied benefits under the plan and therefore, any connection with ERISA.[12]

Thus, the distinction can be summarized as follows:

> Claims challenging the quality of a benefit, as in *Dukes*, are not preempted by ERISA. *See Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151, 154 (10th Cir. 1995) (medical malpractice claim not preempted by ERISA when issue of doctor's negligence required assessment of providing admittedly covered treatment or giving professional advice). Claims based upon a failure to treat where the failure was the result of a

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[12]The Third Circuit cautions that "the distinction between quantity of benefits due under a welfare plan and the quality of those benefits will not always be clear . . . where the benefit contracted for is health care services rather than money to pay for such services." *Dukes*, 57 F.3d at 358. In some cases, "it may be appropriate to conclude that the plan participant or beneficiary has been denied benefits under the plan." *Id.* Such a determination should be made on a case-by-case basis. *See Schmid v. Kaiser Found. Health Plan of Northwest*, 963 F. Supp. 942, 945 n.1 (D. Or. 1997).

> determination that the requested treatment wasn't covered by the plan, however, are preempted by ERISA. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1312, 1331 (5th Cir.), *cert. denied*, 506 U.S. 1033, 113 S. Ct. 812, 121 L. Ed. 2d 684 (1992) (medical determinations made by an HMO preempted by ERISA because made in context of benefits determination under the plan).

Schmid v. Kaiser Found. Health Plan of Northwest, 963 F. Supp. 942, 944 (D. Or. 1997).

In this case, the Act addresses the quality of benefits actually provided. ERISA "simply says nothing about the quality of benefits received." *Dukes*, 57 F.3d at 357. "A reading of . . . [Section] 514(a) resulting in the preemption of traditionally state-regulated substantive law in . . . [an] area[] where ERISA has nothing to say would be 'unsettling.'" *Dillingham*, 519 U.S. at —, 117 S. Ct. at 840 (quoting *Travelers*, 514 U.S. at 664-65, 115 S. Ct. at 1681).

Furthermore, "the Supreme Court has cautioned that '[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan.'" *Cigna*, 82 F.3d at 647 (quoting *Shaw*, 463 U.S. at 100 n.21, 103 S. Ct. 2890, 2901 n.21). For example, "'run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan are not pre-empted." *Corcoran*, 965 F.2d at 1329 (quoting *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 833, 108 S. Ct. 2182, 2187

(discussing these types of claims in dicta)). In addition, "ERISA does not preempt state laws that have 'only an indirect economic effect on the relative costs of various health insurance packages' available to ERISA-qualified plans" such as quality standards. *Cigna*, 82 F.3d at 647 (quoting *Travelers*, 514 U.S. at 659-60, 115 S. Ct. at 1680); *see Dillingham*, 519 U.S. at —, 117 S. Ct. at 840 (noting that if ERISA were concerned with any state action, such as medical care quality standards, that increased costs of providing certain benefits then courts could scarcely see the end of ERISA's preemptive reach); *Pacificare*, 59 F.3d at 154 ("As long as a state law does not affect the structure, the administration, or type of benefits provided by an ERISA plan, the mere fact that the [law] has some economic impact on the plan does not require that the [law] be invalidated."). As such, the Court finds that "*[q]uality control of benefits*, such as the health care benefits provided [by HMOs and other managed care entities], is a field traditionally occupied by state regulation and . . . interprets the silence of Congress as reflecting an intent that it remain such." *Dukes*, 57 F.3d at 357 (emphasis added).

Accordingly, the Court concludes that the Act does not constitute an improper imposition of state law liability on the enumerated entities.[13]

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[13]Plaintiffs also argue that Section 88.002(b) of the Texas Civil Practice and Remedies Code, as added by the Act, improperly imposes vicarious liability on the enumerated entities for the negligent health care treatment decisions of their employees, agents, ostensible agents, or other representatives. (Plaintiff's

ii Mandating the Structure and Administration of Plan Benefits

Next, the Court will examine Plaintiffs' argument that the Act has a connection with ERISA plans because it

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Motion, Instrument No. 20 at 14). Plaintiffs claim that the Seventh Circuit's decision in *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996), calls for this conclusion. In *Jass*, the HMO's agent determined that physical therapy to rehabilitate the plaintiff's knee after her surgery was not necessary. *Id.* at 1485. After suffering permanent damage to her knee, the plaintiff filed a negligence claim against the agent and a vicarious liability claim against the HMO and surgeon. *Id.* The Court dismissed the plaintiff's claim against her HMO for vicarious liability based on the agent's conduct because her cause of action was held to be a Section 502(a) denial of benefits claim, not a quality of care suit. *Id.* at 1491. Thus, the *Jass* case is inapposite since this Court has already determined that a suit may be brought under the Act that challenges the quality of a benefit received.

Furthermore, whether a suit brought under the Act against an HMO for vicarious liability based on the actions of a doctor would be preempted should be determined on a case-by-case basis and would be dependent upon the provisions of the plan and the claims asserted by the plaintiffs. The Court may or may not be required to examine the plan to determine the nature of the relationship between the parties. *See e.g., Jass*, 88 F.3d at 1493 (dismissing vicarious liability claim against HMO based on doctor's conduct because agency relationship was solely a result of HMO's health care plan and because claim required examination of the plan).

improperly mandates the structure of plan benefits and their administration in violation of clear Supreme Court authority. In *Travelers*, the Court noted that, given the objectives of ERISA and its preemption clause, Congress intended for ERISA to preempt "state laws that mandate[] employee benefit structures or their administration." 514 U.S. at 658, 115 S. Ct. at 1678. For example, in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97, 103 S. Ct. 2890, 2900 (1983), the Court held that a New York statute "which prohibit[ed] employers from structuring their employee benefit plans in a particular manner that discriminate[d] on the basis of pregnancy . . . [and another statute] which require[d] employers to pay employees specific benefits . . . clearly 'relate[d] to' benefit plans." ERISA preempted these New York statutes because their "mandates affecting coverage could have been honored only by varying the subjects of a plan's benefits whenever New York law might have applied, or by requiring every plan to provide all beneficiaries with a benefit demanded by New York law if New York law could have been said to require it for any one beneficiary." *Travelers*, 514 U.S. at 657, 115 S. Ct. at 1678. Therefore, "absent preemption, benefit plans would have been subjected to conflicting directives from one state to the next." *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1468 (4th Cir. 1996) (citing *Shaw*, 463 U.S. at 99, 103 S. Ct. at 2901).

Plaintiffs claim that the Act "imposes a 'negligence' standard of review on HMOs and PPOs . . . in contravention of the federally mandated abuse of discretion standard of review of a factual benefit determination under ERISA[,]" and "purports to re-define the standard for 'appropriate and

medically necessary' as it pertains to ERISA plans." (Plaintiffs' Motion, Instrument No. 20 at 15).

With respect to Plaintiffs' first contention, the Court reiterates its conclusion that a suit may only be brought under the Act that challenges the quality of care received, not a benefit determination. Such a claim would not implicate the abuse of discretion standard required under ERISA for factual benefit determinations. *See Pierre v. Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552, 1562 (5th Cir. 1991) (holding that "for factual determinations under ERISA plans, the abuse of discretion standard of review is the appropriate standard"). Whether a claim brought under the Act seeks a review of a plan administrator's factual benefit determination rather than a review of a medical decision should be examined by the Court on a case-by-case basis. At that time, the Court could determine whether or not the particular claim conflicts with the standard of review provided under ERISA.

Plaintiffs also claim that the Act wrongfully purports to redefine the standard for "appropriate and medically necessary" as it pertains to ERISA plans. (Plaintiffs' Motion, Instrument No. 20 at 15). Section 88.001(1) of the Texas Civil Practice and Remedies Code, which was added by the Act, defines "appropriate and medically necessary" as "the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community. TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(1) (West 1998). Plaintiffs contend that "[t]his imposed definition of medical necessity is different from that contained in many

ERISA plans." (Plaintiffs' Motion, Instrument No. 20 at 15). Since Plaintiffs' health care plans purportedly confer authority upon the plan administrator to make coverage determinations in accordance with the terms of the plan, Plaintiffs argue that the Act's definition of "appropriate and medically necessary" changes "the terms of employee benefit plans and restrict[s] the ability of plans to deny claims based upon medical necessity or other terms defined in the plan." (*Id.* at 16).

With respect to the Act's definition of when a health care benefit is "appropriate and medically necessary," the Court must examine this term in conjunction with the procedure provided by the Act for the review of claims relating to an adverse benefit determination by an independent review organization ("IRO"). Section 88.003 of the Texas Civil Practice and Remedies Code, as added by the Act, provides the following:

> (a) A person may not maintain a cause of action under this chapter against a health insurance carrier, health maintenance organization, or other managed care entity that is required to comply with the utilization review requirements of Article 21.58A, Insurance Code, or the Texas Health Maintenance Organization Act (Chapter 20A Vernon's Insurance Code), unless the affected insured or enrollee or the insured's or enrollee's representative:
>
> > (1) has exhausted the appeals and review applicable under the utilization review requirements; or

(2) before instituting the action:

(A) gives written notice of the claim as provided by Subsection (b); and

(B) agrees to submit the claim to a review by an *independent review organization under Article 21.58A, Insurance Code*, as required by Subsection (c).

(b) the notice required by Subsection (a)(2)(A) must be delivered or mailed to the health insurance carrier, health maintenance organization, or other managed care entity against whom the action is made not later than the 30th day before the date the claim is filed.

(c) The insured or enrollee or the insured's or enrollee's *representative must submit the claim to a review by an independent review organization if the health insurance carrier, health maintenance organization, or managed care entity against whom the claim is made requests the review not later than the 14th day after the date notice under Subsection (a)(2)(A) is received* by the health insurance carrier, health maintenance organization, or other managed care entity. If the health insurance carrier, health maintenance organization, or other managed care entity does not request the review within the period specified by this subsection, the insured or enrollee or

the insured's or enrollee's representative is not required to submit the claim to independent review before maintaining the action.

(d) Subject to Subsection (e), if the enrollee has not complied with Subsection (a), an action under this section shall not be dismissed by the court, *but the court may, in its discretion, order the parties to submit to an independent review* or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed 30 days for such purposes. Such orders of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with Subsection (a).

(e) The enrollee is not required to comply with Subsection (c) and no abatement or other order pursuant to Subsection (d) for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(1) harm to the enrollee has already occurred because of the conduct of the health insurance carrier, health maintenance organization, or managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of such carrier, organization, or entity for whose conduct is liable under Section 88.002(b); and

(2) the review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier, organization, or entity finds after that such pleading was not made in good faith, in which case the court may enter an order pursuant to Subsection (d).

(f) If the insured or enrollee or the insured's or enrollee's representative seeks to exhaust the appeals and review or provides notice, as required by Subsection (a), before the statute of limitations applicable to a claim against a managed care entity has expired, the limitations period is tolled until the later of:

(1) the 30th day after the date the insured or enrollee or the insured's or enrollee's representative has exhausted the process for appeals and review applicable under the utilization review requirements; or

(2) the 40th day after the date the insured or enrollee or the insured's or enrollee's representative gives notice under Subsection (a)(2)(A).

(g) This section does not prohibit an insured or enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of

> exhausting the process for appeal and review places the insured's or enrollee's health in serious jeopardy.

TEX. CIV. PRAC. & REM. CODE ANN. § 88.003 (West 1998) (emphasis added).

In addition, the Act amended and added several provisions to the Texas Insurance Code that address specific responsibilities of an HMO and further explain and define the procedure for independent review of an adverse benefit determination by an IRO. *See* TEX. INS. CODE ANN. arts. 20A.09, 20A.12, 20A.12A, 21.58A, and 21.58C (West 1998). Article 20A.09, which was amended by the Act, now requires an HMO to issue evidence of coverage to an enrollee that describes "the enrollee's right to appeal denials of an adverse determination . . . to an independent review organization." TEX. INS. CODE ANN. art. 20A.09(e)(4) (West 1998).

Under the amendments to Article 20A.12 of the Texas Insurance Code, every HMO must establish a complaint system that provides for the "resolution of oral and written complaints initiated by enrollees concerning health care services." *Id.* art. 20A.12(a). The complaint system mandated by Article 20A.12 has several requirements that reference the IRO procedure. Specifically, Article 20A.12A, which was also added by the Act, states that the complaint system must include:

> (1) notification to the enrollee of the enrollee's right to appeal an adverse determination to an independent review organization;

(2) notification to the enrollee of the procedures for appealing an adverse determination to an independent review organization; and

(3) notification to an enrollee who has a life-threatening condition of the enrollee's right to immediate review by an independent review organization and the procedures to obtain that review.

Id. arts. 20A.12A(a) and (b). Article 20A.12A then defines "adverse determination," "independent review organization," and "life-threatening condition." *Id.* art. 20A.12A(c).

The Act also amends Article 21.58A Section 6 of the Texas Insurance Code. If the appeal of an adverse determination is denied, Section 6 now requires the utilization review agent to submit a clear and concise statement to the appealing party informing him of his "right to seek review of the denial by an independent review organization under Section 6A . . . and the procedures for obtaining that review." *Id.* art. 21.58A(6)(b)(5)(C). Furthermore, if the enrollee is faced with a life threatening condition then he "is entitled to an immediate appeal to an independent review organization as provided by Section 6A[.]" *Id.* art. 21.58A(6)(c).

Furthermore, the Act adds a new section 6A to Article 21.58A of the Texas Insurance Code which outlines the utilization review agent's responsibilities with respect to the independent review of adverse determinations. *Id.* art. 21.58A(6A). In particular, Section 6A of Article 21.58A provides that:

A utilization review agent shall:

(1) permit any party whose appeal of an adverse determination is denied by the utilization review agent to seek review of that determination by an independent review organization assigned to the appeal in accordance with Article 21.58C of this code;

(2) provide to the appropriate independent review organization not later than the third business day after the date that the utilization review agent receives a request for review a copy of:

(A) any medical records of the enrollee that are relevant to the review;

(B) any documents used by the plan in making the determination to be reviewed by the organization;

(C) the written notification described in Section 6(b)(5) of this article;

(D) any documentation and written information submitted to the utilization review agent in support of the appeal; and

(E) a list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal;

(3) comply with the independent review organization's determination with respect to the medical necessity or appropriateness of health care items and services for an enrollee; and

(4) pay for the independent review.

Id. art. 21.58A(6A). Notably, under Article 20A.12A, the provisions in Article 21.58A that relate to independent review, namely Section 6A, apply to an HMO as if the HMO were a utilization review agent. *Id.* art. 20A.12A(b). Moreover, given the addition of the IRO procedure by the Act, Section 8 of Article 21.58A now provides that "[c]onfidential information in the hands of a utilization review agent may be provided to an independent review organization" subject to the rules and standards already in effect under the Texas Insurance Code. *Id.* art. 21.58A(8)(f).

Lastly, the Act added Article 21.58C to the Texas Insurance Code. This section outlines the standards for independent review organizations, such as certification requirements. *Id.* art. 21.58C. For example, Article 21.58C explains the Commissioner of the Texas Insurance Board's responsibilities for the certification and designation of independent review organizations and how an entity may be certified as an independent review organization. *Id.*

Plaintiffs argue that an administrator's determination as to "whether a claim for benefits is covered under the medical necessity definition contained in the plan implicates an interpretation of a plan's term." (Plaintiffs' Motion,

Instrument No. 20 at 16). Therefore, Plaintiffs continue, the Act which contains these procedures for an independent review of a benefit determination is preempted because it mandates the structure and administration of benefits.

In response, Defendants maintain that "the IRO is geared solely to corporate determinations of 'medical necessity,' the practice of medicine admittedly being a non-preempted traditional area of state regulation." (Defendants' Response, Instrument No. 46 at 11). Defendants also explain, and Plaintiffs do not dispute, that "[o]nly when AEtna, or another managed care entity, makes adverse determinations that benefits are not medically necessary [do] the IRO provisions [become applicable]." (*Id.* at 14). According to Defendants, "the only possible HMO action that could be called a 'benefit determination' which could ever be grounds for action under the IRO provisions of . . . [the Act] are 'adverse determinations.' Adverse determinations are necessarily limited to 'medical necessity' decisions[.]" (*Id.* at 12).

In *Travelers*, the Supreme Court provided guidance as to the scope of plan administration that Congress intended to protect from state interference. 514 U.S. at 657-68, 115 S. Ct. at 1678. The Court discussed

> earlier decisions which held various state statutes preempted for "mandat[ing] employee benefit structures or their administration." . . . The Court [also] explained that ERISA preempted the statutes at issue in *Shaw* because they imposed "mandates

> affecting coverage" which directly affected the benefit structures which ERISA plans could offer. . . . The law at issue in *FMC Corp. v. Holliday* interfered with benefit calculations; by prohibiting plans from obtaining subrogation, the law frustrated any attempt at providing uniform national benefits. . . . In *Alessi v. Raybestos-Manhattan, Inc.*, . . . ERISA preempted a statute which prohibited plans from using a method of calculating benefits permitted by federal law. . . . In each of these cases, the [Supreme] *Court was concerned with administrative and structural matters central to the administration of ERISA plans themselves.*

American Drug, 973 F. Supp. at 68 (emphasis added) (quoting *Travelers*, 514 U.S. at 657-58, 115 S. Ct. at 1677-78). The Act's use of independent review process implicates the "limited range of administrative functions which are part of operating an employee benefit plan[,]" namely determining the eligibility of claimants. *American Drug*, 973 F. Supp. at 66; *see Fort Halifax*, 482 U.S. at 8-9, 107 S. Ct. 2211, 2216 (1987).

Furthermore, the Act's definition of "appropriate and medically necessary" along with the provisions under Section 88.003 for reviewing an adverse determination by an IRO and the further clarification of the IRO procedure and requirements in Articles 20A.09(4), 20A.12A, 21.58A(6),

(6A), and (8)(f) and 21.58C[14] are akin to the situation addressed by the Fifth Circuit in *Corcoran*. In *Corcoran*, the Court recognized that United gave medical advice, but emphasized that such advice was made or given while administering the benefits under the plan. 965 F.2d at 1331. Consequently, since ERISA preempts state law causes of action alleging the improper handling of benefit claims, the Corcorans' state law claims were preempted by ERISA because part of "United's actions involve[d] benefit determinations." *Id.* at 1332. As in *Corcoran*, by participating in the separate review process provided for under the Act, an insured or enrollee is seeking a review of a benefit determination. Moreover, under Article 21.58A of the Texas Insurance Code, a utilization review agent must comply with the IRO's determination and must pay for the review. TEX. INS. CODE ANN. arts. 21.58A(6A)(3) and (4) (West 1998).

Allowing state based procedures for independent review of an adverse benefit determination, like the one at issue here, "would subject plans and plan sponsors to burdens not unlike those that Congress sought to foreclose through . . . [Section] 514(a). Particularly disruptive is the potential for conflict in state law. . . . Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to

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[14]As mentioned, Article 20A.12 of the Texas Insurance Code requires HMOs to maintain both an oral and a written complaint system. TEX. INS. CODE ANN. art. 20A.12 (West 1998). This article does not discuss the IRO procedure that is addressed by the other amendments.

implement." *Ingersoll-Rand*, 498 U.S. at 142, 111 S. Ct. at 484.

Consequently, as explained by the Supreme Court in *Travelers*, 514 U.S. at 657, 115 S. Ct. at 1677-78, the Court finds that the provisions for an independent review improperly mandate the administration of employee benefits and therefore, have a connection with ERISA plans. *See Coyne*, 98 F.3d at 1468 (indicating that state laws which mandate employee benefit structures or their administration have a connection with ERISA plans). "Congress intended ERISA to preempt state laws[,] [such as the IRO provisions in the Act,] that 'mandate[] employee benefit structures or their administration." *Id.* (quoting *Travelers*, 514 U.S. at 658, 115 S. Ct. at 1678). However, the Court finds that the relevant language in Section 88.003 of the Texas Civil Practice and Remedies Code, the relevant language added by the Act in Articles 20A.09(e)(4), 21.58A(6)(b)(5), and 21.58A(6)(c) of the Texas Insurance Code, and that Articles 20A.12A, 21.58A(6A), 21.58A(8)(f), and 21.58C of the Texas Insurance Code, all addressing the IRO procedure, can be severed from the Act without affecting the other provisions or conflicting with the legislative intent.

"Whether portions of a state statute found to contravene federal law are severable is a question of state law." *Texas Pharmacy*, 105 F.3d at 1039. The Texas Code Construction Act provides that:

> [i]n a statute that does not contain a provision for severability or nonseverability, if any provision of the

> statute or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the statute that can be given effect without the invalid provision or application, and to this end the provisions of the statute are severable.

TEX. GOV'T CODE ANN. § 311.032(c) (West 1988); *see also* TEX. GOV'T CODE ANN. § 312.013 (a) (West 1988) (providing the same standard). Thus, "[u]nder the Texas Code Construction Act, a Texas statute should be deemed severable if the invalidity of one provision does not affect the other provisions, unless it has an express provision for severability or nonseverability." *Texas Pharmacy*, 105 F.3d at 1039; *see In re Johnson*, 554 S.W.2d 775, 787 (Tex. Civ. App.—Corpus Christi, 1977, writ ref'd n.r.e.) (noting that where invalid sections on an act may be separated, the court "must do so and not permit the invalid part to destroy the whole law"). However, the court should "sustain the remainder only if the result is consistent with the original legislative intent." *Black v. Dallas County Bail Bond Bd.*, 882 S.W.2d 434, 437 (Tex. Civ. App.—Dallas 1994, no writ); *see Anderson v. Wood*, 152 S.W.2d 1084, 1087 (Tex. 1941) (concluding that the whole statute was void because the remainder, by reason of its generality, would have given the act a broader scope than was intended by the legislature).

In this case, the Act does not have an express provision for severability or nonseverability of the statute. Furthermore, an examination of the legislative history of the Act reveals the dual purpose that the legislature sought to

achieve with the passage of the Act. Specifically, the legislature sought to address two distinct issues: quality of care and denial of care. With respect to quality of care, the Act establishes a standard of care for HMOs and other managed care entities and allows participants to sue an HMO or a managed care entity for negligent medical decisions. (Index of Legislative History-Testimony of Rep. Smithee. Instrument No. 17, Exh. A at AG01585 and Exh. B at AG01607). With regard to denial of care, the Act creates an independent review process that reviews adverse benefit determinations by an HMO or a managed care entity (*Id.*) In particular, as a prerequisite to filing a lawsuit under the Act, a participant would "be able to get an independent review [of his or her HMO's denial of coverage] by a doctor [in order] to try and get the care" that he or she needs. (Index of Legislative History-Testimony of Rep. Smithee, Instrument No. 17, Exh. B at AG01607). Thus, the Court finds that it was clearly the intent of the legislature to address both the quality of care issue and the denial of care issue under the Act.

The Court has already determined that the IRO provisions concern the review of an adverse benefit determination and are therefore, an improper mandate of benefit administration. As such, the IRO provisions and, in particular, the relevant language in Section 88.003 of the Texas Civil Practice and Remedies Code, the relevant language added by the Act in Articles 20A.09(e)(4), 21.58A(6)(b)(5), and 21.58A(6)(c) of the Texas Insurance Code, and Articles 20A.12A, 21.58A(6A), 21.58A(8)(f), and 21.58C of the Texas Insurance Code would have no effect on lawsuits that may be brought under the Act challenging the

quality of a benefit that an individual has actually received. The Court can still give effect to the provisions of the Act that only address quality of care. In other words, even without these sections which address the IRO procedure, suits addressing the quality of a benefit may still be brought under the Act against an HMO or other managed care entity. This goal under the Act—quality of care—is separate and distinct from the independent review process which solely addresses adverse benefit determinations by a plan administrator or utilization review agent. Thus, upholding the other provisions of the Act is consistent with the legislative intent. Moreover, where the invalid sections of an act may be separated, the Court "must do so and not permit the invalid part to destroy the whole." *In re Johnson*, 554 S.W.2d at 787. Therefore, since the Act can still be given effect without these sections, the Court finds that they may be severed from remainder of the Act.

iii. Binding Employers or Plan Administrators to Particular Choices

The Court agrees with Plaintiffs' next argument that, under existing Fifth Circuit authority, certain provisions in the Act bind employers or plan administrators to particular choices. In *Cigna*, the Fifth Circuit held that the statute had a connection with ERISA plans because it required "ERISA plans to purchase benefits of a particular structure when they contracted with organizations like CIGNA and CGLIC." 82 F.3d at 648. The Court reasoned that:

> ERISA plans that choose to offer coverage by PPOs are limited by the statute to using PPOs of a certain structure—i.e., a structure that includes every willing, licensed provider. Stated another way, the statute prohibits those ERISA plans which elect to use PPOs from selecting a PPO that does not include any willing, licensed provider. As such, the statute connects with ERISA plans.

Id. Furthermore, the Court found that it was "sufficient for preemption purposes that the statute eliminate[d] the choice of one method of structuring benefits." *Id.*; *cf. Dillingham*, 519 U.S. at —, 117 S. Ct. at 842 (holding that prevailing wage statute is not preempted by ERISA because statute merely "alters the incentives . . . but does not dictate the choices, facing ERISA plans").

Later, in *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, the Fifth Circuit relied on its opinion in *Cigna* and determined that Texas's Any Willing Provider statute was preempted by ERISA. 105 F.3d at 1037. The Court explained that "[a]s with the Louisiana statute at issue in *Cigna*, the Texas statute relates to ERISA plans because it 'eliminates the choice of one method of structuring benefits,' by prohibiting plans from contracting with pharmacy networks that exclude any willing provider." *Id.* (citing *Cigna*, 82 F.2d at 648).

Based on the Fifth Circuit's holding in *Cigna* and *Texas Pharmacy*, the Court finds that the Act creates two provisions that bind employers or plan administrators to

particular choices—Sections 88.002(f) and (g) of the Texas Civil Practice and Remedies Code.[15] Section 88.002(f) provides that:

> [a] health insurance carrier, health maintenance organization, or managed care entity *may not remove a physician or health care provider from its plan or refuse to renew the*
> *physician or health care provider* with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

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[15]Plaintiffs also argue that Section 88.002(b) of the Texas Civil Practice and Remedies Code, as added by the Act, "purports to transform the independent contractor relationship [it has with certain providers] into one of agency, express or implied, in contravention of the express terms of the contract." (Plaintiffs' Motion, Instrument No. 20 at 17). Under Section 88.002(b), the named entities are held liable for a negligent health care treatment decision made by its employees, agents, ostensible agents, or other representatives. TEX. CIV. PRAC & REM. CODE ANN. § 88.002(b) (West 1998). To the extent that certain providers are independent contractors, not agents of the HMO, then the court should address that concern on a case-by-case basis. Other suits against a managed care entity for vicarious liability, such as those based on the conduct of an HMO's employee, are still viable. Furthermore, even assuming that Plaintiffs' argument is valid, this consequence does not deny the named entities the right to structure their benefits in a particular manner—they still have the option to employ providers only as independent contractors.

TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(f) (West 1998) (emphasis added). Section 88.002(g) states that:

> [a] health insurance carrier, health maintenance organization, or managed care entity *may not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company which includes an indemnification or hold harmless clause* for the acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity. Any such indemnification or hold harmless clause in an existing contract is hereby declared void.

Id. § 88.002(g) (emphasis added).

Thus, in the instant case, ERISA plans that choose to offer coverage by either a health insurance carrier, HMO, or other managed care entity are limited by the Act to using an entity of a certain structure—i.e., a structure that does not remove a physician or health care provider from its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care and a structure that does not include a prohibited indemnification or hold harmless clause. In other words, the Act prohibits ERISA plans from using a managed care entity that does not conform to the requirements in these provisions. By denying health insurance carriers, HMOs, and other managed care entities the right to structure their benefits in a particular manner, the Act effectively requires ERISA plans to purchase benefits of a

particular structure when they contract with organizations like Plaintiffs. *See Cigna*, 82 F.3d at 648.

Since these provisions require ERISA plans to purchase benefits of a particular structure they essentially cause the Act to have a "connection with" such plans.[16]

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[16]The decisions in *Cigna* and *Texas Pharmacy* clearly hold that these type of provisions have a connection with ERISA plans. Thus, as stated by the Fifth Circuit in *Texas Pharmacy*, this Court notes that "a different result will require further guidance from the Supreme Court or further action from Congress." 105 F.3d at 1040.

A recent district court case from Massachusetts, however, noted that "where a third-party, such as a carrier, provides administrative services for a plan, it is critical to distinguish between the carrier's administration of the ERISA plan and 'its own administration of its business.'" *American Drug*, 973 F. Supp. at 68. In *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, the Court determined that Massachusetts' Any Willing Provider statute did not have a connection with ERISA plans because it did not mandate employee benefit structures or administration. *Id.* at 69. The Court, therefore, found that the statute was not preempted by ERISA. *Id.* The Court reasoned that "the organization and offering of restricted pharmacy networks should be seen as part of the carrier's own administration rather than its administration of ERISA plans." *Id.* at 68. The Massachusetts statute, the Court continued, did not concern administrative and structural matters central to the administration of ERISA plans themselves." *Id.* Furthermore, even more recently, in *Washington Physicians Serv. Ass'n v. Gregoire*, No. 97-35536, 1998 WL 318759, *4 (9th Cir. June

However, the Court finds that these provisions may be severed from the remainder of the statute.

Although these provisions at issue would clearly serve to enhance the quality of care that could be provided, the absence of these sections from the Act does not affect the otherwise valid provisions concerning quality of care. A suit may still be brought under the Act challenging the quality of a benefit actually received. Moreover, upholding the validity of the remainder of the Act is in accord with the legislative

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18, 1998), the Ninth Circuit stated that:

> [t]he mere fact that many ERISA plans choose to buy health insurance for their plan members does not cause a regulation of health insurance to automatically 'relate to' an employee benefit plan—just as a plan's decision to buy an apple a day for every employee, or to offer employees a gym membership, does not cause all state regulation of apples and gyms to 'relate to' employee benefit plans.

Although the Courts in both *American Drug* and *Washington Physicians* present convincing arguments, this Court must find that Sections 88.002(f) and 88.002(g) of the Texas Civil Practice and Remedies Code have a connection with ERISA plans in light of current Fifth Circuit authority. A different result will require Congress to act on the promise to ensure that "'[n]o human being in need of legitimate care should be stopped from getting it.'" Larry Lipman & Rebecca Carr, *Rival Bills Aim to Heal HMO Issues*, ATLANTA J. & ATLANTA CONST., July 17, 1998, at A1 (quoting a statement made by House Speaker Newt Gingrich at the George Washington University Medical Center).

intent. The floor debates as well as the testimony, in support of the Act, given before the Senate Interim Committee on Managed Care and Consumer Protections and the Senate Economic Development Committee reveal the proponents' and the legislature's concern over managed care entities and the lack of quality care. (Index of Legislative History, Instrument Nos. 14, 16). Even though these provisions clearly were designed to promote quality medical care, this goal care be given effect without these invalid provisions and accordingly, the Court finds that they may be severed from the Act.

iv. Alternate Enforcement Mechanism

Lastly, Plaintiffs argue that the liability sections created by the Act, Sections 88.002(a) and (b) of the Texas Civil Practice and Remedies Code, purport to create an alternate enforcement mechanism. (Plaintiffs' Surreply, Instrument No. 53 at 6).

State laws that provide "alternate enforcement mechanisms [for employees to obtain ERISA plan benefits] also relate to ERISA plans, triggering pre-emption." *Travelers*, 514 U.S. at 658, 115 S. Ct. at 1678; *Coyne*, 98 F.3d at 1468 (noting Congress' intent to preempt state laws that provide alternate enforcement mechanisms for employees to obtain ERISA plan benefits). In this case, the Court has already determined that the liability sections of the Act, namely Sections 88.002(a) and (b) of the Texas Civil Practice and Remedies Code, provide a cause of action for challenging the quality of benefits received. Such a lawsuit would not

create an alternate enforcement mechanism for employees to obtain ERISA benefits. *See Dukes*, 57 F.3d at 360-361 (distinguishing between an HMO's denial of plan benefits and an HMO's role as the arranger of a participant's medical treatment which implicates the quality of care that a participant receives). Rather, it would ensure the quality of care that employees actually receive. Whether a claim seeks a review of an adverse benefit determination or to secure quality coverage should be determined by the Court on a case-by-case-basis. *See Schmid*, 963 F. Supp. at 945 n.1 (noting that a "determination of whether or not a particular claim is preempted by ERISA must be made on a case-by-case basis"). It is not apparent to the Court that every claim that may be asserted under the Act would establish an alternate enforcement mechanism for benefit determinations.

Based on the foregoing analysis, the Court holds that Plaintiffs have not met their burden of proving that every claim brought under the Act would be preempted by ERISA. Even though some economic impact may result, a claim concerning the quality of a benefit actually received would remain valid.

VII. FEHBA Preemption

Plaintiffs finally argue that the Act is preempted by FEHBA. In response, Defendants maintain that "FEHBA preemption applies only when there exists a conflict between the particular state law being relied upon in litigation and contractual provisions in a FEHBA policy 'which relate to the nature or extent of coverage of benefits.'" (Defendants' Brief, Instrument No. 11 at 36). According to Defendants, Plaintiffs

fail "to set forth any facts alleging any particular FEHBA policy or contract language conflicting with" the Act. (*Id.*).

Conversely, Plaintiffs argue that FEHBA preemption is required given the Fifth Circuit's decision in *Burkey v. Gov't Employees Hosp. Ass'n*, 983 F.2d 656 (5th Cir. 1993). Plaintiffs contend that Defendants' argument, raised by the plaintiffs in *Burkey*, was clearly rejected by the Fifth Circuit.

As with ERISA, FEHBA provides that state law may be preempted. However, "FEHBA preemption is far more narrow than that of" ERISA. *Arnold v. Blue Cross & Blue Shield of Texas, Inc.*, 973 F. Supp. 726, 732 (S.D. Tex. 1997). Congress expressed its intent to pre-empt state law under FEHBA in 5 U.S.C.A. § 8902(m)(1) (West Supp. 1996), which states that:

> [t]he provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or regulation issued thereunder, to the extent that such law or regulation is inconsistent with such contractual provisions.

This language makes it clear "that Congress did not intend for state law to be entirely preempted." *Arnold*, 973 F. Supp. at 731.

> By expressly limiting the FEHBA's preemptive effect to those laws or regulations that are inconsistent with

> insurance carrier [or health plan] contracts, Congress indicated that courts may not assume that the FEHBA preempts all related state law claims but must instead conduct a case-by case analysis to determine whether a plaintiff's state law claim conflicts with a contractual provision.

Id. at 732 (citing *Transitional Hosps. Corp. v. Blue Cross & Blue Shield of Texas, Inc.*, 924 F. Supp. 67, 70 (W.D. Tex. 1996)). "The policy underlying § 8902(m)(1) is to ensure nationwide uniformity of the administration of FEHBA benefits." *Burkey*, 983 F.2d at 660.

In *Burkey*, a federal employee and her son brought an action against the Government Employees Hospital Association ("GEHA") under Louisiana law "which authorize[d] damages and attorneys' fees for unreasonable delay in paying health and accident insurance claims." 983 F.2d at 657. The Burkeys claimed that GEHA breached its contractual obligation to pay the son's medical bills.

The Fifth Circuit held that "Louisiana's penalty provision [wa]s inconsistent with and therefore preempted by the federal law regulating federal employee health benefits." *Id.* at 657-58. Although the Burkeys argued that their state law claim related to remedies, not the "nature or extent of coverage or benefits[,]" the Court reasoned that "tort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract that governs benefits. . . . [Therefore,] such claims 'relate to' the plan under § 8902(m)(1) as long as they have a connection with or refer

to the plan." *Id.* at 660. "Insofar as the Burkeys' claim for statutory delay damages necessarily refer[red] to GEHA's plan to determine coverage and whether the proper claims handling process was followed, it refer[red] to the plan, 'relate[d] to' it and [wa]s therefore preempted." *Id.*

Unlike the claim asserted by the Burkeys, an individual may file suit under the Act seeking damages for the substandard quality of care actually received. As articulated by the Court under the ERISA preemption analysis, such a suit would not arise out of the manner in which a benefit claim was handled and would not refer to Plaintiffs' plan to determine coverage or whether the proper claims handling process was followed. Therefore, even under *Burkey*, a claim addressing the quality of a benefit received would not "relate to" a FEHBA plan. Moreover, with respect to other claims that one may bring under the Act, a court should conduct a case-by-case analysis to determine whether that claim conflicts with a contractual provision. *See Arnold*, 973 F. Supp. at 732.

VIII. Conclusion

Accordingly, the Court finds that Defendants' and Plaintiffs' motions for summary judgment are **GRANTED in part** and **DENIED in part**. (Instrument Nos. 10 and 20).

The Court **ORDERS** that the Department is dismissed from the lawsuit.

The Court also finds that the following provisions are preempted by ERISA and accordingly, the Court **ORDERS**

them to be severed: Section 88.002(f), Section 88.002(g), Section 88.003(a)(2), Section 88.003(b), Section 88.003(c), the relevant language in Section 88.003(d), Section 88.003(e), and the relevant language in Sections 88.003(f) and (g) of the Texas Civil Practice and Remedies Code, the language added by the Act in Article 20A.09(e)(4), Article 20A.12A, the amendments to Articles 21.58A(6)(b)(5) and 21.58A(6)(c), Article 21.58A(6A), Article 21.58A(8)(f), and Article 21.58C of the Texas Insurance Code.[17]

The Court finds that the remaining provisions of the Texas Civil Practice and Remedies Code and the Texas Insurance Code, as added and amended by the Act, are not preempted by ERISA.

The Clerk shall enter this Order and provide a copy to all parties.

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[17]The Court did not sever Section 88.001(1), the definition of appropriate and medically necessary, from the Act. Given the severance of the mentioned provisions, the inclusion of this definition does not cause the statute to relate to an ERISA plan. It is simply an unnecessary definition because the term was only referenced in Section 88.002(f), which was removed. As such, it could be easily removed without effecting any other provisions in the Act. However, Texas law provides for severance of invalid provisions, not unnecessary provisions. So, the Court declined to remove that section simply because it would produce a clearer, more concise statute. This matter will be left to the decision of the legislature.

SIGNED this 18th day of September, 1998, at Houston, Texas.

VANESSA D. GILMORE
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CORPORATE HEALTH INSURANCE INC., ET AL.	§	
	§	
versus	§	CIVIL ACTION
	§	NO. H-97-2072
THE TEXAS DEPARTMENT OF INSURANCE, ET AL.	§	

FINAL JUDGMENT

For the reasons stated in the Court's Order signed on September 18, 1998, this action is

DISMISSED.

THIS IS A FINAL JUDGMENT.

The Clerk shall enter this Order and provide a copy to all parties.

SIGNED this 18th day of September, 1998.

VANESSA D. GILMORE
UNITED STATES DISTRICT JUDGE

IN THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

NO. 98-20940

CORPORATE HEALTH INSURANCE, INC.;
AETNA HEALTH PLANS OF TEXAS, INC.;
AETNA HEALTH PLANS OF NORTH TEXAS, INC.;
AETNA LIFE INSURANCE COMPANY
Plaintiffs - Appellees-Cross-Appellants,

v.

THE TEXAS DEPARTMENT OF INSURANCE
Defendant - Cross-Appellee,
JOSE MONTEMAYOR, COMMISSIONER OF THE TEXAS
DEPARTMENT OF INSURANCE; JOHN CORNYN,
ATTORNEY GENERAL, STATE OF TEXAS
Defendants - Appellants-Cross-Appellees.

On Appeal from the United States District Court
for the Southern District of Texas,
Houston Division

July 27, 2000

ON PETITION FOR REHEARING

(Opinion June 20, 2000, 5th Cir., 2000 ____F.3d____)
Before HIGGINBOTHAM and PARKER, Circuit Judges.[1]
PATRICK E. HIGGINBOTHAM, Circuit Judge:

The State of Texas petitions for panel rehearing, urging reconsideration of that portion of our opinion in which we concluded that the Independent Review Organization (IRO) provisions appearing in the Texas Insurance Code were preempted. Texas contends that the panel factually misunderstood the IRO provisions and that the recent Supreme Court decision in Pegram v. Herdrich[2] cast doubt on both the panel opinion in this case and this court's prior decision in Corcoran v. United HealthCare, Inc.[3]

In Pegram, the Court held that mixed eligibility and treatment decisions that were made by an HMO acting through its physicians were not fiduciary acts under ERISA, and therefore no federal claim under ERISA for breach of fiduciary duty based on such decisions was stated.[4] Texas points to the Court's observation that such a claim would duplicate state malpractice liability.[5]

The Court's holding in Pegram comports with our holding that certain liability provisions were not preempted, specifically direct liability for physicians' malpractice when making "health care treatment decisions" and the ensuing vicarious liability for the HMOs.[6] However, we do not read Pegram to entail that every conceivable state law claim survives preemption so long

as it is based on a mixed question of eligibility and treatment,[7] and Corcoran held otherwise.[8]

In our panel opinion, we concluded that the IRO provisions allowed review of "adverse determinations" which included "determinations by managed care entities as to coverage, not just negligent decisions by a physician."[9] We held, however, that the IRO provisions "create[d] an alternative mechanism through which plan members may seek benefits due them under the terms of the plan-the identical relief offered under § 1132(a)(1)(B) of ERISA. As such, the independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the savings clause."[10]

Texas insists that the IRO provisions do not create an alternative mechanism for seeking benefits and do not improperly review coverage decisions. According to Texas, the IRO merely implements "a procedural right to obtain medical care . . . by imposing a mandatory insurance contract term that goes to the heart of the insured-insurer relationship."[11] The distinction is a fine one: the IRO provisions reflect Texas's effort to mandate and regulate the quality of medical care for a covered condition, but do not detail or provide a mechanism for determining or receiving benefits.

Under this view, the IRO provisions are alleged to be akin to the state law at issue in Metropolitan Life Ins. Co. v. Massachusetts,[12] which required certain insurers to provide a set level of mental health care as part of their plan policies.[13] Unlike the mandatory benefit provisions in

Metropolitan Life, the IRO provisions allegedly regulate the minimal level of care not through a previously defined set of rules but through an interactive procedure involving independent review of proposed courses of treatment.

A determination by an IRO that a particular treatment is "medically necessary" for a diagnosed condition, however, entails that the treatment must be provided by the HMO - so long as the underlying condition is a covered condition under the plan - because that level of care has become, in some sense retrospectively, a mandatory term of the health plan. This is so because Texas requires HMOs through their utilization review agents to "comply" with the results of the IRO review.[14] According to Texas, however, IRO determinations result in a practical determination of coverage only because the HMO elected to define obligations under its plan in terms of "medical necessity," a standard uniquely within the province of Texas to regulate.

This ambitious spin on the IRO provisions is accented in Texas's petition for panel rehearing. While it is not without some persuasive force, it does not comport with our view of the record, which reflects that the IRO process binds HMOs to pay for treatment the IRO mandates and in so doing substitutes the medical judgment of a third party physician for the HMO's, or treating physician's, judgment as to medical necessity.

Our panel opinion does not hold or suggest that when implementing its police power, Texas cannot deploy an independent review mechanism to regulate the minimal quality

level of medical care provided for covered conditions. Indeed, we explicitly approved an exhaustion requirement prerequisite to the filing of malpractice suits. At the same time, the law is clear that Texas cannot provide a supplementary claims process by binding the HMO to pay for a treatment that is simply a second opinion on medical necessity about which reasonable doctors might reach differing conclusions.

We acknowledge that there is a powerful argument in support of an IRO procedure in which the only inquiry is whether a proposed treatment meets the standard of care demanded by Texas of physicians - *i.e.*, whether any reasonably prudent physician in the relevant community could have made the medical decision or prescribed the course of treatment. The argument is that Texas can demand this level of care as a mandated term of insurance for covered conditions regardless of whether an HMO chooses to define the scope of its coverage in terms of its own definition of medical necessity.[15]

Under this view, what Texas can regulate through malpractice suits, Texas could also administratively regulate as a mandated term of insurance. The independent review would not be a second opinion about which reasonable physicians might disagree. Rather the inquiry would be confined to whether providing the medical services found to be necessary would constitute medical malpractice. The ultimate contention is that Congress never intended to preempt a state's power to regulate the quality of medicine; that so confined the IRO is the natural companion of the provision authorizing suits for medical malpractice by treating physicians and brings symmetry to the structure.

Because the IRO provisions here are plainly a state regime for reviewing benefit decisions and not a system for implementing a mandated term of insurance regulating a minimal standard of care, we have no occasion to decide whether that form of regulation could be saved, and, if so, implemented by regulations limiting the standard of review to the question of whether it will be medical malpractice to deliver the services determined to be necessary in the decision being reviewed. We remain persuaded that the original panel decision is sound and panel rehearing is DENIED.

The Petition for Rehearing is DENIED and no member of this panel nor judge in regular active service on the court having requested that the court be polled on Rehearing En Banc (Fed. R. App. P. and 5th Cir. R. 35), the Petition for Rehearing En Banc is also DENIED.

MOTION FOR PANEL REHEARING and PETITION FOR REHEARING EN BANC DENIED.

1. This matter is being decided by a quorum, 28 U.S.C. 46(d).

2. 120 S. Ct. 2143 (2000).

3. 965 F.2d 1321 (5th Cir. 1992).

4. 120 S. Ct. at 2158.

5. See id. at 2157-58.

6. Corporate Health v. Texas Dep't of Ins., No. 98-20940, 2000 WL 792345, at *4, *5 (5th Cir. June 20, 2000); see also id. at *5 n.34. But see Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1996). In Jass, the Seventh Circuit held that vicarious liability claims against an HMO based on the malpractice of a treating physician were preempted because the necessary agency determination would require an analysis of the underlying health care benefit plan and thus would "relate to" the benefit plan. Id. at 1493.

The alleged negligence at issue in Jass, however, was not the treating physician's negligent provision of services but rather the physician's failure to provide care once coverage had been denied. While that distinction was not the only basis for the court's holding, it was found to be significant. See id. In our panel opinion, we expressly distinguished that situation and held only that direct and vicarious liability claims were not preempted when based on the actual negligent provision of medical services. See Corporate Health, 2000 WL 792345, at *4-5.

7. It may be that state causes of action persist only for actions based in some part on malpractice committed by treating physicians. If so, state causes of actions against HMOs for the decisions of their utilization review agents would still be preempted, as Corcoran held. Because Pegram did not exhaustively discuss the specific kinds of state causes of action that it implied were not preempted, we make no additional inferences.

8. See 965 F.2d at 1332-33, 1326.

9. See Corporate Health, 2000 WL 792345, at *6.

10. Id. at *7.

11. Petition for Panel Rehearing, at 13-14 (internal quotation marks omitted).

12. 471 U.S. 724 (1985).

13. See id. at 731, 758 (holding that a state law mandating the provision of a particular level of mental health care - viz., "60 days of coverage for confinement in a mental hospital, coverage for confinement in a general hospital equal to that provided by the policy for nonmental illness, and certain minimum outpatient benefits" - was saved from preemption).

14. See Corporate Health, 2000 WL 792345, at *6 & n.40 (citing Tex. Ins. Code art. 21.58A § 6A(3)).

15. Cf. UNUM Life Ins. Co. of Am. v. Ward, 119 S. Ct. 1380, 1390 (1999) (declining to find that an insurer can "displace any state regulation simply by inserting a contrary term in plan documents").

VERNON'S TEXAS STATUTES AND CODES
INSURANCE CODE
TITLE 1
CHAPTER TWENTY A--HEALTH MAINTENANCE ORGANIZATION ACT

Art. 20A.12A. Appeal of Adverse Determinations

(a) In this section:

(1) "Adverse determination" means a determination by a health maintenance organization or a utilization review agent that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary or are not appropriate.

(2) "Independent review organization" means an organization selected as provided under Article 21.58C, Insurance Code.

(3) "Life-threatening condition" has the meaning assigned by Section 6, Article 21.58A, Insurance Code.

(b) A health maintenance organization shall implement and maintain an internal appeal system that provides reasonable procedures for the resolution of an oral or written appeal concerning dissatisfaction or disagreement with an adverse determination that is initiated by an enrollee, a person acting on behalf of an enrollee, or an enrollee's provider of record.

The appeal system must include procedures for notification, review, and appeal of an adverse determination, as defined by this section, in accordance with Article 21.58A, Insurance Code.

(c) When an enrollee, a person acting on behalf of an enrollee, or an enrollee's provider of record expresses orally or in writing any dissatisfaction or disagreement with an adverse determination, the health maintenance organization or utilization review agent shall regard the expression of dissatisfaction or disagreement as an appeal of the adverse determination, as defined by this section, and shall review and resolve the appeal in accordance with Article 21.58A, Insurance Code.

(d) A health maintenance organization may integrate its appeal procedures related to adverse determinations with the complaint and appeal procedures established by the health maintenance organization under Section 12 of this Act only if the procedures related to adverse determinations comply with this section and Article 21.58A, Insurance Code.

VERNON'S TEXAS STATUTES AND CODES
INSURANCE CODE
TITLE 1. THE INSURANCE CODE OF 1951
CHAPTER TWENTY-ONE--GENERAL PROVISIONS
SUBCHAPTER E. MISCELLANEOUS PROVISIONS

Art. 21.58A. Health Care Utilization Review Agents

Appeal of Adverse Determinations of Utilization Review Agents

Sec. 6.

(c) Notwithstanding this article or any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an independent review organization as provided by Section 6A of this article and is not required to comply with procedures for an internal review of the utilization review agent's adverse determination.

VERNON'S TEXAS STATUTES AND CODES
INSURANCE CODE
TITLE 1. THE INSURANCE CODE OF 1951
CHAPTER TWENTY-ONE--GENERAL PROVISIONS
SUBCHAPTER E. MISCELLANEOUS PROVISIONS

Art. 21.58A. Health Care Utilization Review Agents

Appeal of Adverse Determinations of Utilization Review Agents

Independent review of adverse determinations

Sec. 6A. A utilization review agent shall:

(1) permit any party whose appeal of an adverse determination is denied by the utilization review agent to seek review of that determination by an independent review organization assigned to the appeal in accordance with Article 21.58C of this code;

(2) provide to the appropriate independent review organization not later than the third business day after the date that the utilization review agent receives a request for review a copy of:

(A) any medical records of the enrollee that are relevant to the review;

(B) any documents used by the plan in making the determination to be reviewed by the organization;

(C) the written notification described by Section 6(b)(5) of this article;

(D) any documentation and written information submitted to the utilization review agent in support of the appeal; and

(E) a list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal;

(3) comply with the independent review organization's determination with respect to the medical necessity or appropriateness of health care items and services for an enrollee; and

(4) pay for the independent review.

VERNON'S TEXAS STATUTES AND CODES
INSURANCE CODE
TITLE 1
CHAPTER TWENTY A--HEALTH MAINTENANCE ORGANIZATION ACT

Art. 20A.09. Evidence of Coverage and Charges

(e) Each evidence or coverage must contain a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:

(1) the medical, health care services, limited health care services, or single health care service and the issuance of other benefits, if any, to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan;

(2) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or co-payment feature;

(3) where and in what manner information is available as to how services may be obtained; and

(4) a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints, including the enrollee's right to appeal denials of an adverse

determination, as that term is defined by Section 12A of this Act, to an independent review organization and the procedures for making an appeal to an independent review organization. Any subsequent changes may be evidenced in a separate document issued to the enrollee.

VERNON'S TEXAS STATUTES AND CODES
INSURANCE CODE
TITLE 1. THE INSURANCE CODE OF 1951
CHAPTER TWENTY-ONE--GENERAL PROVISIONS
SUBCHAPTER E. MISCELLANEOUS PROVISIONS

Art. 21.58A. Health Care Utilization Review Agents

Appeal of Adverse Determinations of Utilization Review Agents

Sec. 6.

(b) The procedures for appeals must be reasonable and must include the following:

> (5) written notification to the appealing party of the determination of the appeal, as soon as practical, but in no case later than the 30th calendar day after the date the utilization agent receives the appeal. If the appeal is denied, the written notification shall include a clear and concise statement of:
>
> > (A) the clinical basis for the appeal's denial;
> >
> > (B) the specialty of the physician or other health care provider making the denial; and

(C) notice of the appealing party's right to seek review of the denial by an independent review organization under Section 6A of this article and the procedures for obtaining that review.

(3)

MOTION FILED

NOV 2 1 2000

No. 00-665

In The

Supreme Court of the United States

JOSE MONTEMAYOR, COMMISSIONER OF THE TEXAS DEPARTMENT OF INSURANCE; JOHN CORNYN, ATTORNEY GENERAL OF TEXAS,

Petitioners,

v.

CORPORATE HEALTH INSURANCE, INC.; AETNA HEALTH PLANS OF NORTH TEXAS, INC.; AETNA LIFE INSURANCE COMPANY,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

MOTION FOR LEAVE TO FILE AMICUS CURIAE BRIEF AND BRIEF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AS AMICUS CURIAE IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

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MOTION FOR LEAVE TO FILE AMICUS CURIAE BRIEF

The National Association of Insurance Commissioners (NAIC) respectfully moves this Court, pursuant to Rule 37.2(b), for leave to file a brief as an amicus curiae in this case in support of the Petition for a Writ of Certiorari, and in support of its motion states:

1. Counsel of record for NAIC attempted to obtain the consent of all parties to the filing of an amicus curiae brief by NAIC by contacting the parties' counsel of record.

2. The Petitioners, Jose Montemayor, Commissioner of the Texas Department of Insurance, and John Cornyn, Attorney General of Texas, have consented to the filing of an amicus curiae brief by NAIC through their counsel of record, David C. Mattax, of the Office of the Attorney General of Texas.

3. None of the Respondents have replied to NAIC's request for their consent.

4. NAIC has a strong interest in this case as set out fully in the brief submitted with this motion.

WHEREFORE, premises considered, the National Association of Insurance Commissioners respectfully moves this Court for leave to file a brief as amicus curiae.

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INTEREST OF AMICUS CURIAE[1]

The National Association of Insurance Commissioners (NAIC) is a non-profit corporation comprised of the chief insurance regulators in each state, four territories and the District of Columbia. The NAIC assists these officials in the pursuit of fundamental insurance regulatory objectives, including: (1) maintaining and improving state regulation in a responsive and efficient manner; (2) maintaining the reliability of insurance business with respect to financial solidity and guarantees against loss; and (3) ensuring fair, just and equitable treatment of policyholders and claimants.[2]

The issues before this Court implicate the NAIC's objectives because they address whether the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.* (1999), preempts state laws that regulate insurance within the meaning of ERISA's saving clause, § 514(b)(2)(A).

The NAIC adopted the Health Carrier External Review Model Act (Model Act), Model No. 75, *I NAIC Model Laws, Regulations and Guidelines* (2000), on October 4, 1999. Generally, the Model Act provides for independent review of health carrier coverage decisions based on medical judgment. By adopting this Model Act, the NAIC declared that the independent review of certain claims determinations furthers the NAIC mission – to ensure the fair, equitable and just treatment of insurance consumers.[3] The Fifth Circuit's decision in *Corporate Health*

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[1] Counsel for a party did not author this brief in whole or in part. No person or entity, other than this Amicus Curiae, made a monetary contribution to the preparation and submission of this brief.

[2] NAIC Constitution, Article II. Mission Statement, *I NAIC Proceedings*, 1997, at iv.

[3] *Id.*

Ins. v. Texas Dep't of Ins., 215 F.3d 526 (5th Cir. 2000), obstructs insurance regulators' ability to protect insurance consumers.

SUMMARY OF ARGUMENT

This Court should grant the Petition for a Writ of Certiorari in *Jose Montemayor, Comm'r of the Texas Dep't of Ins.; John Cornyn, Attorney Gen. of Texas v. Corporate Health Ins. Inc.*, No. 00-665. There is a clear conflict in the circuit courts because of differing interpretations of this Court's opinion in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

The Fifth Circuit holding in *Corporate Health* cannot be reconciled with the Seventh Circuit holding in *Moran v. Rush Prudential HMO, Inc.*, No. 99-2574, 2000 U.S. App. LEXIS 26053 (7th Cir. Oct. 19, 2000). There is also a conflict between the Fifth Circuit in *Corporate Health* and the Second Circuit in *Franklin H. Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144 (2d Cir. 1995). State independent review laws are of great public importance because they ensure that consumers get the benefits to which they are entitled. The Fifth Circuit decision threatens to invalidate this critical consumer protection enacted in a majority of states.

This Court should hold that Texas's independent review law is not preempted by ERISA, because it does not create an alternative enforcement mechanism. *Moran*, 2000 U.S. App. LEXIS 26053 at *31. Texas's law adds terms to insurance contracts, which are enforceable through suits under ERISA. *See, UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 375-376 (1999). This Court should also hold that § 514's insurance saving clause, by its plain language, limits the preemptive effect of § 502.

ARGUMENT

A. There is a Conflict in the Circuit Courts Regarding Whether State Independent Review Laws Create Alternative Enforcement Mechanisms to § 502; and Whether Such Laws, if Held to Provide a Remedy Supplemental to § 502, are Nevertheless Saved From Preemption as Laws Regulating Insurance.

This case presents two conflicts that arise out of disparate readings of *Pilot Life v. Dedeaux*, 481 U.S. 41.[4] *Pilot Life* involved a claim for disability benefits. The respondent, Everate W. Dedeaux, filed various common law tort and contract actions seeking damages for Pilot Life's denial of his disability benefit claims. All Mr. Dedeaux's common law causes of action were held to "relate to" an ERISA plan. This Court, however, reviewed whether Mississippi's common law cause of action for insurer bad faith in the handling of Mr. Dedeaux's disability claim would otherwise be "saved" as a law regulating insurance under ERISA § 514(b)(2)(A). This Court found that it was not such a law. Mississippi's law of bad faith was derived from general tort and contract law principles and as such, was not specifically directed at the insurance industry. Therefore, the law did not "regulate insurance" from a common-sense perspective. *Id.* at 50.[5]

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[4] While we agree that the other issues addressed by Petitioners have merit, we have focused on issues that apply uniquely to laws regulating insurance.

[5] The law met one of a possible three McCarran-Ferguson factors: (1) the common law tort of bad faith did not effect a spreading of the risk; (2) the law's connection to the insurer-insured relationship was attenuated at best; and (3) the law was not limited to entities within the insurance industry. 481 U.S. at 50-51.

While unnecessary to the holding that ERISA preempts Mississippi's common law of insurer bad faith, this Court also considered the role of the civil enforcement provisions provided in ERISA § 502. *Id.* at 51-57. This Court stated that ERISA's civil enforcement scheme, including the remedies it provided, was intended to be exclusive, further supporting its conclusion that the bad faith claim was preempted.[6] *Id.* at 52. In support of this declaration, this Court cited the language and structure of § 502, as well as legislative history stating that § 301 of the Labor Management Relations Act of 1947 (LMRA), 29 U.S.C. § 141 *et seq.* (1999) was the model for § 502. *Id.*

1. The Fifth Circuit decision in *Corporate Health* and the Seventh Circuit decision in *Moran* conflict as to whether state independent review laws provide an alternative enforcement mechanism to ERISA § 502.

The Courts of Appeals for the Fifth Circuit and the Seventh Circuit reached opposite conclusions regarding whether ERISA preempts state independent review laws. On October 19, 2000, the Seventh Circuit decided *Moran*, which involved Illinois's independent review law. 215 Ill. Comp. Stat. 125/4-10 (West Supp. 2000). Contrary to the Fifth Circuit decision in *Corporate Health*, the Seventh Circuit held that Illinois's independent review law was not preempted under ERISA.

According to the Seventh Circuit, the independent review law regulated insurance within the meaning of the saving clause, and did not provide an alternative enforcement mechanism in conflict with ERISA § 502. 2000 U.S. App. LEXIS 26053 at *25, *31. The independent review

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[6] We are not conceding the meaning or impact of this statement at this time. *See infra part C.*

law merely added to the insurance contract a supplemental "internal" procedure used to make a medical necessity decision in the event that the HMO and a patient's primary care physician disagree. *Id.* at *32. The Seventh Circuit observed that the determination of the reviewing physician would be enforced under § 502(a)(1)(B), and therefore the independent review law alters the plan itself, rather than the mechanism to enforce the plan. *Id.*

The Fifth Circuit in *Corporate Health* reached the opposite conclusion with respect to Texas's independent review law. The Fifth Circuit, citing *Pilot Life*, emphasized that § 502 preempts not only directly conflicting remedial schemes, but also supplemental state law remedies. The Fifth Circuit determined that Texas's independent review provision was a law regulating insurance within the meaning of the saving clause. 215 F.3d at 538. The independent review law was nevertheless preempted, because it conflicted with the remedies of § 502 by creating an alternative procedure for obtaining benefits due under an ERISA plan. *Id.* at 539 (citations omitted).

The three-judge appellate panel that decided *Moran* conceded that its decision conflicted with the Fifth Circuit's decision in *Corporate Health* by circulating its opinion to the active members of the court pursuant to Rule 40(e).[7]

The Seventh Circuit voted against rehearing the case *en banc*.[8] The dissent agreed that "[t]he panel's decision creates a square conflict . . . " with the Fifth Circuit. 2000 U.S. App. LEXIS 26053 at *36.

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[7] "To the degree that our views differ from those of the Fifth Circuit, we find ourselves in respectful disagreement and therefore have circulated this opinion under Circuit Rule 40(e)." 2000 U.S. App. LEXIS 26053 at *35 n.7.

[8] Four judges voted for rehearing and joined the dissent drafted by Chief Judge Richard Posner. Circuit Judges Coffey, Easterbrook, and Wood joined the dissent.

Texas's and Illinois's independent review laws are very similar. They both provide for independent physician review of coverage determinations made by managed care organizations based on whether a covered service is medically necessary.[9] Accordingly, this Court should grant the Petition for a Writ of Certiorari in order to resolve the conflict.

2. There is a conflict between the Fifth Circuit decision in *Corporate Health* and the Second Circuit decision in *Franklin Trust* as to whether the insurance saving clause can preserve from preemption a state law regulating insurance that provides a remedy.

The Fifth Circuit in *Corporate Health* interpreted *Pilot Life* as requiring the preemption of a state independent review law that was otherwise "saved" as an insurance law within the meaning of ERISA § 514(b)(2)(A), because it conflicted with one of the causes of action available under ERISA § 502. The Fifth Circuit described a conflict with § 502 as including "not only directly conflicting remedial schemes, but also supplemental state law remedies." 215 F.3d at 539 (citations omitted). Notwithstanding *Pilot Life's* language invoking Congress's intent that ERISA's remedies be exclusive, the Second Circuit has held that laws regulating insurance within the meaning of the saving clause may provide remedies and enforcement mechanisms that supplement, without abrogating, the remedies available under § 502 of ERISA.

The Second Circuit in *Franklin Trust* determined that ERISA did not preempt enforcement of a New York law that regulated insurance within the meaning of ERISA

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[9] 215 Ill. Comp. Stat. 125/4-10 and Tex. Ins. Code art. 20A.12A; 21.58A § 6(c); 21.58A § 6A; 20A.09(e), and 21.58A § 6(b) (West 2000).

§ 514(b)(2)(A).[10] The Second Circuit explained that "[i]t would be quixotic to rule that a claim under a state statute that is saved from ERISA preemption . . . may nonetheless be enforced only via ERISA provisions and remedies." 50 F.3d at 151. This holding contradicts the Fifth Circuit's decision in *Corporate Health*. In *Corporate Health*, the Fifth Circuit determined that even though the independent review law regulated insurance within the meaning of § 514(b)(2)(A), it was preempted under ERISA § 502 because it provided "plan members" an alternative method for obtaining benefits under an ERISA plan. 215 F.3d at 539.

The Supreme Court should grant a writ of certiorari in order to resolve the conflict between the Fifth Circuit and the Second Circuit.

B. *Corporate Health* Raises Compelling Issues of Great Public Importance.

1. The resolution of conflicts regarding the validity of state independent review laws are of great public importance.

Independent review laws are critical to state consumer protection efforts because they address consumer concerns about the decisions made by managed care plans involving their health care.[11] Independent review

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[10] *Franklin Trust* involved a plaintiff's motion to remand after removal of a state law cause of action for damages based on the failure of Travelers Life Insurance Company to comply with N.Y. Ins. Law § 3214(c) (1999). This provision encourages timely claims payments by requiring that statutory interest on life insurance proceeds be computed from the date of death. The Second Circuit held that removal was improper because ERISA did not preempt the New York insurance law.

[11] "[External review programs] are meant to address concerns about managed care incentives that might lead to

laws were adopted in the states in the wake of decreased consumer confidence in the health care system and managed care in particular.[12] State independent review laws are intended to improve the quality of care provided by the plan, and consumers benefit from the knowledge that an independent, unbiased review of a health plan's decision is available.[13] It is an insurance regulator's primary responsibility to protect the interests of insurance consumers[14] and independent review is heralded as being "a fair, impartial and usually expeditious way to resolve disputes."[15]

Managed care requires cost containment, which creates tension between the provision of care on the one hand, and saving money on the other. *Pegram v. Herdrich*, 120 S.Ct. 2143, 2149 (2000). Independent review laws ameliorate policyholder concerns and impose a measure of accountability on managed care plans.[16]

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inappropriate denial of care, and to help restore public confidence in managed care." Karen Pollitz, Geraldine Dallek and Nicole Tapay, Institute for Health Care Research and Policy, Georgetown University, *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare*, Nov. 1998, at 1, 7 [hereinafter *External Review of Health Plan Decisions*].

[12] *Managed Care Regulation and Oversight in Nine States*, Issue Brief, National Governor's Association Center for Best Practices, June 28, 2000, at 2-3.

[13] Geraldine Dallek and Karen Pollitz, Institute for Health Care Research and Policy, Georgetown University *External Review of Health Plan Decisions: An Update*, May 2000, at 1 [hereinafter *External Review Update*].

[14] NAIC, *A Tradition in Consumer Protection*, 1998, at 1.

[15] *External Review of Health Plan Decisions, supra* note 11, at 1.

[16] *See* The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Quality*

To date, 38 states plus the District of Columbia have enacted independent review laws. The Kaiser Family Foundation updated its November 1998 study of independent review laws in May 2000 documenting a doubling in the number of such state laws.[17]

While there are some differences among the state approaches to external review laws, they all require an HMO to utilize an independent reviewer to resolve certain coverage disputes. Differences among the laws include the role of the state regulator in the independent review process,[18] and whether only insureds, or also their doctors, may request an independent review.[19]

Independent review systems typically evaluate and resolve at least those disputes involving medical issues.[20] Most states' independent review laws provide that the decision of the reviewer is binding on one or both of the parties.[21] Approximately half of the states that make the

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First: Better Health Care for All Americans, Final Report to the President of the United States (1998) (recommending that an independent review process be available to consumers). *See also External Review of Health Plan Decisions, supra* note 11.

[17] *External Review Update, supra* note 13.

[18] Sixteen states' independent review laws require that requests for independent review be filed with the insurance commissioner or another state agency. NAIC, *External Grievance Review Procedures*, Oct. 1, 2000, at 2-4 (*available in* www.naic.org/1whatsnew/) [hereinafter *NAIC Chart*].

[19] Seventeen states' independent review laws authorize a provider, under certain circumstances, to request independent review. *Id.* at 6-10. Three states authorize the insurer to request independent review. *Id.*

[20] *External Review of Health Plan Decisions, supra* note 11, at iii.

[21] Twenty-eight states' independent review laws specifically provide that the reviewer's decision is binding. *NAIC Chart, supra* note 18, at 73-76. Eleven of those states' laws

reviewer's decision binding, specifically provide that the decision is subject to judicial review.[22] Prohibition of conflicts of interest among the independent reviewer, the HMO and the case under review are also frequently included.[23] Another common provision requires that experts with clinical expertise in the area that is the subject of the dispute conduct the review.[24] Independent review laws are widely regarded as fair and useful in strengthening consumer confidence in managed care.[25]

The NAIC's Model Act provides that individuals may obtain independent review of certain adverse determinations made by an insurer or its agent. In general, the Model Act is typical of the kinds of independent review laws enacted in the states. In recognition of the variation in state external review laws, the Model Act includes three options. Each option differs in the degree to which the insurance regulator is involved in the independent review process.

It is important to preserve independent review laws regulating insurance company benefit decisions, because this Court's decision in *Firestone Rubber v. Bruch*, 489 U.S. 101 (1989), granted significant deference to insurance companies that deny claims by participants in ERISA plans. *Firestone* held that courts would presumptively

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specify that the reviewer's decision is binding with respect to both the insurer and the individual seeking review. *Id.* Five of those states' laws specify that the reviewer's decision is binding only on the insurer. *Id.* An additional six states do not explicitly state that they bind the insurer, but instead, require that the insurer comply with the independent reviewer's decision. *Id.*

[22] Thirteen states' independent review laws specifically mention that a reviewer's decision is subject to judicial review. *Id.*

[23] *Id.* at 49-56.

[24] *Id.* at 39-49.

[25] *External Review of Health Plan Decisions, supra* note 11.

review ERISA benefit determinations de novo, but that "a deferential standard of review [is] appropriate" when the decision maker is given "discretionary powers." *Id.*

This Court tempered its decision by noting that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.' " *Id.* at 115, (quoting Restatement (Second) of Trusts § 187, cmt. d (1959)). Since *Firestone* was decided in 1989, the circuits have struggled to apply this command to benefit decisions by insurance carriers who, by definition, labor under a structural conflict of interest. The Third Circuit in *Pinto v. Reliance Standard*, 214 F.3d 377, 382-393 (3rd Cir. 2000), has heroically reviewed the circuits' efforts and the resulting multiple circuit splits.

While more rigorous than many of its sister circuits, the Third Circuit concluded that it could "find no better method to reconcile *Firestone's* dual commands than to apply the arbitrary and capricious standard, and integrate conflicts as factors in applying that standard, approximately calibrating the intensity of our review to the intensity of the conflict." *Id.* at 393.

By passing independent review laws, state legislatures have expressed the judgment that insurers do not deserve deference when they are engaged in medical decision making to determine insurance coverage. Entrusted by ERISA with the regulation of insurance, the legislatures have determined that only a person free of conflicts should be permitted to make final decisions of such delicacy, discretion, and life or death importance.

The high percentages of reversals by state independent reviewers proves both the wisdom and importance of preserving these state laws from federal preemption.

The 1998 Kaiser Family Foundation Study compiled disposition statistics of state independent review laws.[26] The study found that independent reviewers reversed nearly as many health plan decisions as they upheld, overturning health plan decisions between 32 and 68 percent of the time.[27]

2. State laws that regulate insurance and add an enforcement mechanism or other remedy to those provided by ERISA § 502 are an important part of the regulation of insurance reserved for the states in § 514(b)(2)(A).

The Fifth Circuit held that Texas's independent review law provided a remedy to plan members seeking benefits, and that ERISA preempts all such supplemental state remedies, regardless of the application of the saving clause. This rationale directly threatens private parties seeking to enforce certain state insurance laws, and applied broadly, may even call into question the enforcement authority of state insurance regulators.

State laws that provide remedies are a critical part of the regulation of insurance. Without enforcement provisions, such laws would be ineffective. Yet, this is the consequence of the Fifth Circuit's decision.

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[26] The following is a list of states, their effective dates and the percentage of cases that were decided in favor of the consumer. Connecticut – January 1998 – 66%; Florida – 1985 – 60%; Michigan – 1978 – 39%; Missouri – 1994 – 50%; New Jersey – 1997 – 42%; New Mexico – March 1997 – 50%; Pennsylvania – 1991 – 37%; Rhode Island – 1997 – 68%; Texas – November 1997 – 48%; Vermont mental health law – November 1996 – 33%. *External Review of Health Plan Decisions, supra* note 11, at vii-viii.

[27] *Id.* at iv.

Several states provide insureds with causes of action for unfair claims payment practices.[28] ERISA explicitly recognizes the states' continuing ability to regulate insurance. But insurance regulation is significantly impaired if ERISA is construed to preempt state provisions for private remedies and methods of enforcing that law. *See Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988) (relying on the purportedly exclusive nature of § 502's remedies to invalidate a law of this type).

We do not believe the Fifth Circuit's rationale goes so far as to preclude state insurance regulator actions to enforce laws such as those governing unfair claim practices. However, some Courts might erroneously fail to distinguish state insurance regulator enforcement actions that result in orders to pay claims, as well as penalties.

C. The Fifth Circuit Decision is Incorrect; Independent Review Laws do not Provide Remedies that Conflict with § 502, and Even if They are Remedies, They are Subject to the Saving Clause.

1. *Pilot Life* did not take into account the presumption against preemption, which has informed this Court's recent preemption opinions.

This Court's recent ERISA preemption cases emphasize Congress's intent to reserve to the states those laws

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[28] Mich. Comp. Laws § 500.2006 (2000) (private right of action for certain delayed claims payments); N.M. Stat. Ann. § 50A-16-30; § 50A-16-20 and § 50A-16-21 (2000) (private right of action for insurer's failure to pay claims in a timely manner); Wyo. Stat. § 26-15-124 (2000) (private right of action against insurer based on wrongful refusal to provide benefits). Ala. Code § 27-12-24 (2000) and 42 Pa. Cons. Stat. Ann. § 8371 (1999) (tort of insurer bad faith).

that are part of their historic police powers. The United States observed in its Brief as Amicus Curiae, LEXIS 1997 U.S. Briefs 1868 at *24, *UNUM* (No. 97-1868), that this Court's recent recognition of this presumption against preemption reinforces the force of the plain meaning of ERISA's saving clause (citing *New York Conference of Blue Cross Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995); *see also De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 n. 8 (1997), *California Div. of Labor Standards Enforcement v. Dillingham Construction N.A.*, 519 U.S. 316, 325 (1997)). In light of the post-*Pilot Life* recognition of the importance of preserving state law, this Court should revisit the issue of whether state laws that regulate insurance are preempted, merely because they provide a remedy.

2. State independent review laws do not add alternative enforcement mechanisms to ERISA.

Both the Fifth Circuit in *Corporate Health* and the Seventh Circuit in *Moran* recognized that the independent review laws at issue regulated insurance within the meaning of ERISA's saving clause, § 514(b)(2)(A). The court in *Moran*, however, reasoned that Illinois's independent review law was not an alternative enforcement provision that conflicted with ERISA § 502. The court stated that the "independent review scheme . . . is not tantamount to the relief offered under ERISA § 502(a)(1)(B)." 2000 U.S. App. LEXIS 26053 at *31. The independent review law becomes a substantive term in all insurance policies. Therefore, an action to enforce the decision of an independent reviewer can be brought under § 502 as an action to enforce the terms of the plan. *Id.*[29]

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[29] The dissent from denial of rehearing en banc in *Moran* suggested that two issues were unresolved. First, Illinois's independent review law undermines "the statutory purpose of

Indeed, Texas's independent review law is indistinguishable from other state laws that are not preempted; it regulates insurance and is enforceable by a participant in a suit under 502(a)(1)(B) to recover benefits. Such laws include mandated benefits laws, which add covered benefits to the terms of an insured ERISA plan (*Metropolitan Life*), as well as laws that change the terms of an insured plan by adding procedural protections to assure that covered benefits promised by the insurer are actually delivered (*UNUM*). Unquestionably then, a state law may alter an insurer's claims procedure to the point of changing the outcome of a claim, without running afoul of preemption.

Similarly, there would be no basis for challenging other state laws aimed at insurance carriers that adjust the method by which carriers decide claims. The law at issue here is no different. The state is merely prescribing the qualifications of the person who has the authority to decide a type of claim. As in *UNUM*, where a participant could only enforce the notice-prejudice rule through a suit pursuant to Section 502(a)(1)(B) of ERISA, the

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federal uniformity in the administration of ERISA plans." *Moran* at *39. This Court rejected this argument in *Metropolitan Life Ins. Co. v. Massachusetts* by recognizing that "disuniformities are the inevitable result of the congressional decision to 'save' local insurance regulation." 471 U.S. 724, 747 (1985).

Second, Illinois's independent review law could not both regulate insurance and become a part of the ERISA plan enforceable in federal court. *Moran* at *41. The dissent misunderstands the relationship between laws that regulate insurance and ERISA. *See FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990); *UNUM*, 526 U.S. 358, 375; and *Pegram*, 120 S.Ct. at 2151.

determination of the state approved decision maker here, can only be enforced through ERISA.[30]

3. The saving clause § 514(b)(2)(A) should be read as limiting the preemptive effect of § 502.

Pilot Life's observation that laws regulating insurance cannot supplement the remedies provided by § 502 of ERISA was dicta. 481 U.S. at 54. *Pilot Life* did not involve a law which regulated insurance. *Id.* at 51. Thus, it was not necessary for this Court in *Pilot Life* to say that Congress intended that all remedies that relate to ERISA plans, regardless of whether or not they regulate insurance, are to be the exclusive vehicle for beneficiary recovery.[31] *Id.* at 52. Accordingly, the language in *Pilot Life* regarding Congress's intent for ERISA's remedies to be exclusive should be limited to state laws that relate to an ERISA plan, but are outside the scope of the saving clause. *See* Brief for the United States as Amicus Curiae at LEXIS 1997 U.S. Briefs 1868 *22-*24, *UNUM* (No. 97-1868).[32]

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[30] *See* Brief of the Secretary of Labor as Amicus Curiae at 18, *Moran* (No. 99-2574) (*available in* www.dol.gov/pwba/public/pubs/ab/moranfin.txt).

[31] *See Franklin Trust; Hill v. Blue Cross Blue Shield of Alabama*, No. 00-AR-1590-S, 2000 U.S. Dist. LEXIS 15132 (N.D. Ala. Oct 10, 2000); *Selby v. Principal Mutual Life Ins. Co.*, No. 98 Civ. 5283, 2000 U.S. Dist. LEXIS 1495 (S.D. N.Y. Feb. 16, 2000); *Lewis v. Aetna U.S. Healthcare*, 78 F. Supp. 2d 1202 (W.D. Okla. 1999).

[32] *But see Kanne*, 867 F.2d 489, *In re Life Ins. Co. of N. Am.*, 857 F.2d 1190, 1194-1195 (8th Cir. 1988).

a. Under the plain language of ERISA, the insurance saving clause applies to all provisions of title I of ERISA, including § 502.

ERISA's express preemption provision, § 514, explains the relationship between ERISA and other laws. Section 514(a) states that, "[e]xcept as provided in subsection (b) of this section, the provisions of this title [title I] and title IV shall supercede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." This Court has often described the "expansive sweep" of this provision. *Pilot Life*, 481 U.S. at 47 (citations omitted).

Congress, however, included § 514(b)(2)(A), the saving clause, as an exception to the otherwise sweeping federal preemption in § 514(a). ERISA § 514(b)(2)(A) states that "[e]xcept as provided in subparagraph (B),[33] nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance."[34]

Based on the language of the statute, the interaction of these two sections explains that ERISA preempts state laws that relate to ERISA plans, unless they regulate insurance. This Court supported this interpretation in *Metropolitan Life*, 471 U.S. at 733, 735, and in *Pilot Life* before the issue of § 502 is discussed. 481 U.S. at 47.

By the plain language of the statute, ERISA § 502 is subject to the saving clause. The saving clause provides that nothing in title I, which includes § 502, shall be construed to exempt or relieve any person from "any

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[33] Referencing the deemer clause, which provides that a state cannot deem an ERISA plan an insurer for the purpose of regulating it. The deemer clause is not at issue in this case.

[34] Laws that regulate banking and securities are also exempted from the preemptive scope of § 514(a).

law" of any state. Thus, the Fifth Circuit's decision in *Corporate Health* is inconsistent with the statute.

The Fifth Circuit determined that Texas's independent review law supplemented ERISA's remedies under § 502, and was therefore preempted regardless of the saving clause. This holding fails to recognize that § 502 is specifically subject to the saving clause because "any law" is saved, not as the Fifth Circuit would have it, "any law except a law that provides a remedy."

If Congress intended to save all laws that regulate insurance from preemption, except those that provide remedies, it would have said so in § 514(b)(2)(A). Section 514(a) already includes one exception, subsection (B), for laws that deem ERISA plans to be insurers. Surely, Congress would have included another exception, if it meant to provide one.

This Court in *Pilot Life* states that the comprehensive nature of the language and structure of § 502 "provide[s] strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly." 481 U.S. at 54 citing *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985). Applying this statement to all state laws, including those that regulate insurance within the meaning of § 514(b)(2)(A), unjustifiably discounts the language and structure of the entire ERISA statute, and the saving clause in particular. This Court should hold that § 502 provides the exclusive remedy only where a state law that relates to an ERISA plan is not within § 514's saving clause.[35] The Court should not resort to legislative history where the words of the statute are plain. *See Harris Trust and Saving Bank v. Salomon Smith Barney Inc.*, 120 S.Ct. 2180, 2190 (2000) (citations omitted). As explained below, the legislative

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[35] *See UNUM*, 526 U.S. at 376 (acknowledging without deciding Government's argument to same effect).

history of § 502 is an unreliable guide to the proper interpretation of the saving clause.

b. The legislative history of ERISA is misleading, because the analogy to § 301 of LMRA is flawed.

In *Pilot Life*, this Court reasoned that, based on the legislative history of ERISA,[36] Congress intended to federalize ERISA remedies under § 502 the same way that § 301 of LMRA had federalized remedies for violation of collective bargaining agreements. 481 U.S. at 55. Consequently, according to this Court in *Pilot Life*, the federal remedies available under § 502 displace state causes of action. *Id.* at 56.

This Court should reconsider this conclusion. There are obvious and fundamental differences between LMRA and ERISA. In contrast to ERISA, LMRA is an entirely federal law that occupies the field of employer-employee contractual relationships and does not contain a saving clause.

ERISA, with the inclusion of the saving clause, clearly contemplates that both state and federal laws apply to insured ERISA plans. *See Metropolitan Life*, 471 U.S. at 727-747; *UNUM*, 526 U.S. at 375-377. Therefore, Congress's intent to pattern § 502 after § 301 of LMRA does not inform the treatment of a state cause of action that regulates insurance within the meaning of the saving clause. Brief for the United States as Amicus Curiae,

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[36] This Court references the remarks of Senator Javits and H.R. Rep. No. 93-533 at 12 (1973) *reprinted in* 2 Senate Committee on Labor and Public Welfare, Legislative History of ERISA, 94th Cong., 2d Sess., 2359 (Comm. Print 1976). 481 U.S. at 56.

LEXIS 1997 U.S. Briefs 1868 at *25, *UNUM* (No. 97-1868); *see also* Brief of the Secretary of Labor as Amicus Curiae at 19-20, *Moran* (No. 99-2574). Accordingly, this Court should not read ERISA's legislative history as limiting the saving clause.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be granted.

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No. 00-665

IN THE

Supreme Court of the United States

JOSE MONTEMAYOR, Commissioner of the Texas Department of Insurance, JOHN CORNYN, Attorney General of Texas,

Petitioners,

v.

CORPORATE HEALTH INSURANCE, INC.; AETNA HEALTH PLANS OF TEXAS, INC.; AETNA HEALTH PLANS OF NORTH TEXAS, INC.; AETNA LIFE INSURANCE COMPANY,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF *AMICI CURIAE* TEXAS WATCH, RUBY CALAD AND WALTER PATRICK THORN IN SUPPORT OF PETITIONERS

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STATEMENT OF INTEREST

Amici curiae are Texas Watch, Ruby Calad, and Walter Patrick Thorn.[1]

Texas Watch is an advocacy organization that serves to protect consumers by encouraging fair and professional treatment from insurance companies and HMOs. Both Texas Watch's constituency and the individual *amici* are directly affected by the issues raised in the petition for writ of certiorari pertaining to the scope of ERISA preemption of the Texas Health Care Liability Act's liability and independent-review provisions.

Ms. Calad and Mr. Thorn are individuals who have asserted under the 1997 Texas Health Care Liability Act that their HMOs denied them treatment on alleged "medical necessity" grounds. In Ruby Calad's case, Ms. Calad underwent a hysterectomy with rectal, bladder, and vaginal repair. Despite the very serious nature of this surgery, Ms. Calad's HMO authorized only one day for her hospital stay. Not qualifying under her HMO's "medical necessity" criteria for a continued stay, Ms. Calad suffered further pain when she was forced out of the hospital prematurely. Had her HMO deferred to and relied upon the advice and recommendation of Ms. Calad's treating physician, she would have remained in the hospital for additional time to recover from the traumatic surgery. Instead, Ms. Calad endured needless pain and suffering that resulted in her coming to the emergency room, just days after her premature discharge, with life-threatening complications.

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1. This *amici curiae* brief filed in support of the Petitioners was funded solely by the *amici* and authored entirely by counsel for the *amici*.

Mr. Thorn suffered severe injuries to his left hand in a car accident, requiring the amputation of his ring finger in the emergency room. Two physicians at the emergency room advised Mr. Thorn that another surgery would have to be performed promptly, within two to three days, in order to save the rest of his hand. Despite the recommendations of his primary-care physician and hand specialist, Mr. Thorn's HMO initially refused to authorize the surgery on "medical necessity" grounds, delaying the treatment for almost a week. As a result of this delay, Mr. Thorn has suffered greatly reduced mobility in, and use of, his hand.

Amici support the Petitioners, who seek review of the Fifth Circuit decision entered June 20, 2000, as well as the later decision denying rehearing, in the case styled *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, reported at 215 F.3d 526 (5th Cir. 2000) and 220 F.3d 641 (5th Cir. 2000), respectively. While the Fifth Circuit correctly held that ERISA does not preempt the liability and anti-retaliation provisions of the Texas Health Care Liability Act, these decisions wrongly concluded that the Act's provisions for independent review of HMO "medical necessity" decisions were preempted. Without extensive analysis, the Fifth Circuit simply concluded that the IRO regime, which serves to review an HMO's decisions on the "medical necessity" of treatment, "is squarely within the ambit of ERISA's preemptive reach." 215 F.3d at 537.

But the Fifth Circuit failed to properly apply this Court's decision in *Pegram v. Herdrich*, which held that HMO physicians making medical-necessity decisions are *not* making either fiduciary or administrative decisions, but are engaging in "mixed decisions" identical to those made by doctors in millions of other contexts — decisions that ERISA

does not preempt. Because of the way that HMOs define what they will and will not "cover," essentially entering the realm of medical-necessity decision-making, HMOs are engaging in the practice of medicine historically regulated by the states, a result neither intended nor supported by the legislative history of the Federal HMO Act.

For these reasons, *amici* support the petition filed by Jose Montemayor, Commissioner of the Texas Department of Insurance, and John Cornyn, Attorney General of Texas. Given the importance of the IRO provisions to consumers, *amici* believe they can assist the Court in addressing whether ERISA preempts those provisions, and urge this Court to grant a writ of certiorari in this case.

SUMMARY OF ARGUMENT

Texas' petition for writ of certiorari thoroughly details the split in circuit-court authority, analyzes ERISA's savings clause, and presents related reasons for this Court to grant the petition for writ of certiorari. *Amici* agree with all the points made, and write separately only to emphasize two further reasons for granting the writ: First, the Court's opinion in *Pegram v. Herdrich* signals broad acceptance of the idea that "mixed" eligibility and treatment decisions within an HMO structure implicate only state-law concerns and not ones covered by ERISA[2] — an idea that ought logically result in a holding that Texas' independent-review-organization ("IRO") legislation is also properly the province of state rather than federal law. Second, *Pegram*'s reliance, for part of its analysis, on the Health Maintenance

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2. Employee Retirement Income Security Act of 1974, 29 U.S.C.A. §§ 1001, *et seq.*

Organization Act of 1973[3] — a statute predating ERISA by a year — makes useful an examination of the legislative history of that Act, for considering it in tandem with ERISA's purpose and intended scope yields further support for the validity of Texas' IRO legislation.

ARGUMENT

1. *Pegram v. Herdrich*: Congress did not intend for ERISA to preempt health-care issues, nor to set up a federalized system of treating medical-necessity determinations, when made by an HMO, as fiduciary in nature.

Earlier this year the Court held that mixed treatment and eligibility decisions made by an HMO, acting through its physicians, are not fiduciary acts under ERISA. *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000). Asked to hold that an HMO physician's delaying needed medical care to save money for the HMO and increase the physician's compensation breaches ERISA's fiduciary-duty provisions, the Court unanimously said no. Though *Pegram* did not involve whether ERISA preempts state legislation creating an independent body to review concurrent and prospective medical treatment and to opine on its necessity, the Court's reasoning is nonetheless instructive, and controlling here.

Pegram is but the latest, in fact, of a line of cases in which this Court has noted that ERISA's preemptive reach was not so broad as earlier thought; beginning in 1995, the Court handed down a trilogy of cases reining in the notion that ERISA preempts any law that could be said to in any

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3. 42 U.S.C.A. §§ 300e, *et seq.*

way "relate to" an employee-benefit plan. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 117 S. Ct. 832 (1997); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 117 S. Ct. 1747 (1997). Conversely, according to *Pegram*, recognizing an ERISA fiduciary-based remedy for what is essentially a state-law medical-malpractice claim would entail a federalized standard of reasonable medical care and "raise a puzzling issue of preemption":

> On its face, federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the subject of a state-law malpractice claim. See 29 U.S.C. § 1144 (preempting state laws that "relate to [an] employee benefit plan"). [*Pegram*, 120 S. Ct. at 2158.]

But noting that *Travelers* "throws some cold water on the preemption theory," the Court summed up that case's core holding: "[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Id.*

And, importantly, the health-care issues before the Court in *Pegram* were ones found to be "inextricably mixed": administrative, coverage-type decisions (always preempted) and pure treatment decisions (the subject, most plainly, of state malpractice laws):

> It will help to keep two sorts of arguably administrative acts in mind. *Cf. Dukes v. U.S.*

> *Healthcare, Inc.*, 57 F.3d 350, 361 (C.A.3 1995) (discussing dual medical/administrative roles of HMOs). What we call pure "eligibility decisions" turn on the plan's coverage of a particular condition or medical procedure for its treatment. "Treatment decisions," by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response? [*Id.* at 2153-54.]

The Court then concluded that Herdrich's complaint raised "just such *mixed* eligibility and treatment decisions," giving as examples

> physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than [the HMO's]; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition. [*Id.* at 2155.]

Another way to phrase these types of decisions is, of course, that they are ones of "medical necessity."

The next section of the *Pegram* decision signaled the end of ERISA preemption of mixed eligibility decisions — a category that naturally subsumes medical-necessity determinations — with Justice Souter opining that Congress "did not intend" for an HMO to be considered a fiduciary "to the extent that it makes mixed eligibility decisions acting through its physicians. We begin with doubt that Congress

would ever have thought of a mixed eligibility decision as fiduciary in nature." *Id.* Because those types of decisions are not fiduciary ones under ERISA, the Court's conclusion effectively ends ERISA preemption of state-law claims focused on an HMO's medical-necessity decisions, since they are by definition mixed eligibility ones.[4]

Though a finding of no fiduciary status with regard to medical-necessity decisions is not necessarily tantamount to a broader finding that ERISA does not preempt other types of claims arising from such decisions (a question the Court has not faced until now), the holding and reasoning in *Pegram*, especially when coupled with this Court's recently developed and consistent view that Congress did not intend ERISA to preempt a subject of traditional state regulation such as health care, lead logically to just such a result.[5]

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4. *Pegram* would also seem to implicitly disapprove the Fifth Circuit's earlier decision in *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), which held just such "mixed" decisions to be preempted. On petition for rehearing in the instant case, the Fifth Circuit rejected that view. 220 F.3d 641, 643-44 (5th Cir. 2000) ("[W]e do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment, and *Corcoran* held otherwise." (Footnotes omitted.)).

5. Too, just one week after deciding *Pegram*, this Court denied an HMO's petition for writ of certiorari in *Bauman v. U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999), *cert. denied*, 2000 U.S. Lexis 4177, 68 U.S.L.W. 3773 (June 19, 2000). In *Bauman*, the Third Circuit held that ERISA did not completely preempt the plaintiffs' claims that their HMO's failure to approve an in-home pediatric nurse visit led to their newborn daughter's death from an undiagnosed and untreated strep infection. ("[I]t is the HMO's

(Cont'd)

Here, the Texas IRO legislation does nothing more than regulate the *quality* of medical care — the practice of medicine — by providing a mechanism for plan participants to obtain a medical "second opinion" about whether a particular course of treatment is indeed medically necessary. Because it implicates, at most, a mixed treatment issue, that legislation falls squarely within the ambit that Congress — and this Court — recognize as being reserved to the states.

The *Pegram* Court made it clear that mixed decisions are nothing more than medical-treatment decisions made "millions of times every day"[6] in other contexts, and that the decisions in those contexts are subject to state law. The most plausible conclusion to draw from *Pegram* is that even when an HMO arrogates to itself the "medical necessity" second-guessing function by the way that it writes its coverage agreement, the medical-necessity analysis by the HMO's medical director would not trigger preemption — and state law continues its vital role in regulating the HMO's health-care treatment decisions.

(Cont'd)
essentially medical determination of the appropriate level of care that the Baumans claim contributed to the death of their daughter. . . . Accordingly, the claim fits squarely within a class of claims that we identified in *Dukes* as involving the quality of care [and thus not preempted].") 193 F.3d at 163. Apparently rejecting the HMO's argument that the Baumans sought to recover for a denial of benefits — normally a preempted claim — this Court's denial of the petition for writ of certiorari shows that *Pegram*'s holding and reasoning are not limited to the narrow question of fiduciary status for a malfeasant HMO.

6. 120 S. Ct. at 2156.

In short, given the development in caselaw from *Travelers* through *Pegram*, and the evolving refinements to preemption issues that this Court's decisions represent, the Fifth Circuit erred in holding the IRO portions of the Texas Health Care Liability Act preempted. And because some thirty-four states and the District of Columbia have enacted similar independent-review procedures, this is an issue of national importance.[7]

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7. 2000 Alaska Sess. Laws 99, ARIZ. REV. STAT. ANN. § 20-2537 (West Supp. 1999), CAL. [INS.] CODE § 10169 (West Supp. 2000), COLO. REV. STAT. § 10-16-113.5 (West 1999), CONN. GEN. STAT. § 38a-478n (West Supp. 2000), DEL. CODE ANN. tit. 16, § 9119 (2000), D.C. CODE § 32-571.7 (Lexis Supp. 2000), 2000 Fla. Laws ch. 00-256 (West), GA. CODE ANN.§ 33-20A-32 (2000), 2000 Haw. Sess. Laws 250, 215 ILL. COMP. STAT. 125/4-10 (West Supp. 2000), IND. INS. CODE ANN. § 27-13-10.1-1 (West 2000), IOWA CODE ANN. § 514J (West 2000), KAN. STAT. ANN. § 40-22a13 (Supp. 1999), 2000 Kentucky Laws Reg. Sess. 262 (West), LA. REV. STAT. ANN. § 22:3081 (2000), 2000 Me. Legis. Serv. 742 (West), MD. CODE ANN. [INS.] §§ 15-10A through 15-10B (Lexis Supp. 1999), 2000 Mich. Legis. Serv. 251 (West), MINN. STAT. ANN. § 62Q.73 (West Supp. 2000), MO. REV. STAT. § 376.1385 (1997), MONT. CODE ANN. § 33-37-102 (1999), N.H. REV. STAT. ANN. 420-J:5 (2000), N.J. STAT. ANN. §§ 26:2S-11, 26:2S-12 (West Supp. 2000), N.M. ADM. CODE tit. 13, § 10.17.24 (Michie Supp. 2000), N.Y. [INS.] LAW § 4904 (McKinney 1999), N.C. GEN. STAT. §§ 58-50-61, 58-50-62 (1998), OHIO REV. CODE ANN. § 1751.84 (Baldwin Supp. 2000), OKLA. STAT. ANN. tit. 63, § 2528.3 (West 1999), 40 PA. CONS. STAT. § 991.2162 (1998), R.I. GEN. LAWS § 23-17.12-10 (Lexis Supp. 2000), 2000 S.C. Acts 380, TENN. CODE ANN. § 56-32-227 (West 1999), UTAH CODE ANN. § 31A-22-629 (2000), VT. STAT. ANN. tit. 8, § 4089f (1998), VA. CODE § 38.2-5900 to 38.2-5905 (Michie Supp. 2000), 2000 Wash. Legis. Serv. 5 (West), 2000 Wisc. Legis. Serv. 155 (West).

2. The background and purpose of the 1973 Federal HMO Act show that Congress did not intend to remove medical-necessity issues from health-care providers — or from the states.

In addition to the aspects of *Pegram* discussed above, the Court also made explicit the usefulness of considering Congress's enactment of the Health Maintenance Organization Act of 1973 just one year before it enacted ERISA: in the Court's view, Congress could hardly have meant to encourage the formation of HMOs only to stifle them a year later by (if Herdrich's interpretation were accepted) including a fiduciary-duty standard in ERISA whose enforcement would entail "nothing less than elimination of the for-profit HMO." *Pegram*, 120 S. Ct. at 2156.[8]

While debate could be had on this latter conclusion (a debate not called for here), the pertinent point for the instant case is this: when considering whether Congress meant for ERISA to preempt state-law quality-of-care/medical-necessity regulation of HMOs, such as Texas' IRO provisions, examining the federal HMO Act's legislative history is just as useful as examining that of ERISA itself. To *amici*'s knowledge, no case to date has done so, thus presenting the Court with an opportunity to delve more deeply into just how the two acts should be interpreted in tandem for preemption purposes.

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8. The *Pegram* Court noted that "for over 27 years the Congress of the United States has promoted the formation of HMO practices" and that federal courts would be "acting contrary to the congressional policy of allowing HMO organizations if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure, untethered to claims of concrete harm." 120 S. Ct. at 2156-57.

Analysis of the federal HMO Act — principally its 1973 legislative history and that of later specific amendments — shows that Congress intended the *states* to regulate HMO quality, including medical-necessity determinations, and never contemplated that HMOs would be able to arrogate to themselves the practice of medicine through a statute (ERISA) requiring almost unquestioning deference to a plan administrator's "benefit" decision. Stated another way, there is no demonstrable congressional intent to create, or even to show cognizance of, a process whereby *health plans* take from treating doctors, and the states, the determination of what care is appropriate, i.e., medically necessary.

Several portions of the legislative history support *amici*'s view:

First, though Congress explored implementing a comprehensive federal regulation of HMO quality through a Commission on Quality Health Care Assurance,[9] it ultimately decided *not* to create such a commission, instead leaving quality-of-care regulation to the states. Indeed, the only preemption provisions that were enacted addressed states' barriers to the formation of HMOs, such as those prohibiting prepaid plans.[10]

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9. Much of the 1973 Senate Report dealt with the proposed commission, but the actual HMO Act dropped it altogether when finally enacted. *See* S. REP. No. 93-129 (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033.

10. *Id.* at 3057 ("Section 1243 in this bill preempts restrictive state laws which impair the formation or operation of health maintenance organizations and health service organizations. Several

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But even when Congress was seriously contemplating regulating and overseeing HMO quality of care at the federal level, it recognized that some oversight and control by the states was appropriate. For example, in a separate section of the Senate Report, entitled "State Standards," the Committee on Labor and Public Welfare discussed the proposed Commission on Quality Health Care Assurance, making clear that local (i.e., state) concerns would govern health-care standards applicable to HMOs:

> [The Committee] is of the opinion that *the states*, through a designated state agency, *should be given the opportunity to develop health care standards* so that local and other variations can be taken into account though the Commission would have to assure itself that such standards would at least be as effective and rigorous as those the Commission itself would otherwise institute. The Commission is aware, for instance, that disease patterns and treatment methodologies do differ, and appropriately so, from state to state.[11]

(Cont'd)

states have laws which restrict group practice, the corporate practice of medicine, and impose other conditions for approval. Under this section, providers of health care receiving quality health care initiative awards under title III are given the authority to function regardless of restrictive state legislation. As of May 1971, twenty-two states continued to have laws prohibiting prepaid group practice."). *See* 42 U.S.C.A. § 300e-10(a).

11. *Id.* at 3077 (emphasis added).

And in the following paragraph, the Senate Committee stated:

> An added factor in this Committee's decision to *encourage states* to *develop their own standards* is the fact that experience in the medical care field has indicated that the closer the responsibility for standard development of health care regulation is to the actual provider of the care, the more likely the provider is to become involved in the development and setting of standards. The result is that these providers are more responsive to these standards when they have assisted in the development of the standards.[12]

As the HMO Act was initially conceived, the Committee thus envisioned that each state should be given the opportunity to enforce its own promulgated HMO-quality standards, and nothing in the subsequent Conference Report or floor debate negates this clear congressional intent that (a) treating medical professionals, not HMOs, would determine "medical necessity"; and (b) the states would be responsible for administering HMO quality standards for health care, including "medical necessity." And since Congress ultimately rejected establishing a federal commission that would have, to some extent, usurped state control, its intent is clear: quality-of-care issues — including those of medical necessity — were best left *entirely* to state control and regulation.

Elsewhere in the Senate Reports for the 1973 Act, it is apparent that the Committee on Labor and Public Welfare

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12. *Id.* (emphasis added).

considered that the HMO structure would actually *remove* any financial incentives from the practice of medicine at the physician level, thereby — again — leaving medical-necessity determinations to the actual health-care providers and also, by logical extension, to the states, which were implicitly (in the Act as enacted) given sole authority to regulate the field of health care:

> The medical group approach also provides opportunity for a restructuring of financial incentives. A health professional's income is not related directly to the number of services he provides, thereby removing a major incentive for over-utilization of services. In addition, it allows the *health professionals* to make judgments *based on medical necessity alone*.[13]

This language has never received substantial attention, especially in analyzing the interplay between the Federal HMO Act and ERISA, passed the very next year. Though *Pegram* recognized the importance of the two acts adopted one year apart, that opinion did not explore the actual legislative history. When that is done, it becomes inconceivable that with the federal HMO Act Congress (a) meant to facilitate the removal of any financial incentives affecting medical-necessity determinations and to encourage "health professionals" and not HMOs to "make judgments based upon medical necessity alone," but (b) with ERISA, the very next year, it somehow intended to bestow on employee benefit plans, or on HMO providers contracting with ERISA plans, the ability to circumvent the prior year's intent that "*health professionals* [would make] judgments

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13. *Id.* at 3047 (emphasis added).

based on *medical necessity alone*." This conclusion is bolstered considerably by Congress's decision to leave all quality-of-care issues — including ones of medical necessity — to state control.

Also noteworthy is that proposed section 1311(A) of the Act would have permitted a state agency or court to assert its jurisdiction under state law over any "health issue" not affected by standards or criteria promulgated under § 1302 of the Act.[14] The absence of any manifested intent even here to preempt state-law quality-of-care standards, and the eventual adoption of an Act that allows total state-law enforcement of health-care standards, effectively negates any argument that the federal HMO Act began an attempt by Congress to allow federal preemption under the guise of either the HMO Act or ERISA, one year later, of state-law medical-necessity regulation.

And in the 1976 legislative session, just two years after enacting ERISA, Congress considered but rejected a federal-court remedy for enrollees of an HMO who were given assurances by an HMO, directly or indirectly, about basic and supplemental health services.[15] The conference substitute noted that rejecting the Senate's proposed federal remedy "[did] not change any existing right of individuals to bring suit in state courts."[16] This legislative history indicates that

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14. Section 1302 set forth the proposed functions of the (ultimately jettisoned) Commission.

15. H.R. CONF. REP. NO. 94-1513 (1976), *reprinted in* 1976 U.S.C.C.A.N. 4355, 4366.

16. *Id.*

Congress did not intend to preempt even state-law fraud claims against HMOs, an intent evinced a mere two years after it enacted ERISA.

At bottom, it makes no sense to suppose that just one year after adopting the federal HMO Act — which deliberately left HMO quality-of-care regulation to the states — Congress intended through ERISA to supplant the states' ability to regulate the quality of medical care that HMOs provide. And nothing in ERISA's later development indicates any congressional intent, at any time, to override the clear intent contained in the HMO Act: that the states would be the ones to adopt and enforce HMO medical-care/health-care regulation.

Viewed in this light, Texas' IRO provisions simply fulfill what Congress envisioned when it decided to encourage the limited formation of HMOs some 27 years ago. What Congress gave the states with one hand — the ability to settle on appropriate quality-of-care standards — it did not take away with the other. As Justice Souter signaled in *Pegram*, it is wholly appropriate to consider the HMO Act when analyzing ERISA's preemptive effects on state laws that seek to establish the level of quality medical care that an HMO must provide. It would add considerably to the extant body of ERISA caselaw if this Court were to grant the petition for writ of certiorari and expound on the interplay between the two acts, especially given the large number of states that have enacted laws similar to the Texas IRO legislation.

CONCLUSION

This case presents an important issue: Can a state lawfully adopt legislation ensuring that its citizens get medically necessary care from an HMO operating within that state's borders? Based on this Court's holding in *Pegram* and on the legislative history of the 1973 HMO Act, the answer is plainly yes. *Amici* respectfully urge this Court to grant the petition for writ of certiorari so that it can fully consider whether the Fifth Circuit erred in its contrary answer.

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No. 00-665

In the
Supreme Court of the United States

JOSE MONTEMAYOR, COMMISSIONER OF THE TEXAS DEPARTMENT OF INSURANCE; JOHN CORNYN, ATTORNEY GENERAL OF TEXAS,

Petitioners,

v.

CORPORATE HEALTH INSURANCE, INC.;
AETNA HEALTH PLANS OF TEXAS, INC.;
AETNA HEALTH PLANS OF NORTH TEXAS, INC.;
AETNA LIFE INSURANCE COMPANY,

Respondents.

On Petition for Writ of Certiorari
To the United States Court of Appeals
For the Fifth Circuit

BRIEF OF THE STATES OF MASSACHUSETTS, ALABAMA, ARIZONA, ARKANSAS, COLORADO, FLORIDA, ILLINOIS, KANSAS, LOUISIANA, MARYLAND, MICHIGAN, MISSISSIPPI, MISSOURI, MONTANA, NEW HAMPSHIRE, NEW MEXICO, OHIO, OKLAHOMA, PENNSYLVANIA, SOUTH CAROLINA, UTAH, VERMONT AND WASHINGTON, AND THE NORTHERN MARIANA ISLANDS AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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INTEREST OF THE AMICI CURIAE

The 24 amici curiae states, through their attorneys general, respectfully submit this brief in support of the petition for writ of certiorari filed by the state of Texas. The states have a strong interest in protecting state insurance laws from being preempted by the Employee Retirement Income Security Act of 1974 (ERISA). Moreover, the states have an interest in protecting their ability to enforce state insurance laws that have a direct impact on their citizens' health under managed health care systems. The protection secured by the state statute at issue in this case is widely considered an important and effective safeguard in preventing underutilization by managed care organizations ("MCOs").[1]

Most state citizens' health care insurance is purchased through their employers and utilizes some form of managed health care.[2] Managed care organizations act as both a health care provider and health care insurer. Utilization review has become a fundamental component of managed care. The general purpose of health management organizations, eighty-two percent of which were for profit institutions in 1996, is to attempt to contain costs and increase profits through utilization review.[3] There is a natural tendency within the managed care

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[1]Geraldine Dallek and Karen Politz, Institute for Health Care Research and Policy, Georgetown University *External Review of Health Plan Decisions: An Update*. (May 2000) at 6 [hereinafter *External Review Update*].

[2]Recent statistics show that 75% of all Americans with health insurance have managed care provisions. *See* Sandra Kaufmann Battaglia, *Managed Care or Managed Costs?* 18 Delaware Lawyer 21 (2000).

[3] Mark O. Hielper & Brian C. Dunn, *Irreconcilable Differences: Why the Doctor-Patient Relationship is Disintegrating at the Hands of Health Maintenance Organizations and Wall Street*, 25 Pepp. L. Rev. 597, 603-04 (1998).

environment to limit care and to provide the least expensive care available. When MCOs override a physician's decision regarding the medical necessity of a treatment or procedure, the patient will likely choose not to undergo the treatment or procedure. If states are not able to regulate the utilization review processes of managed care organizations, then they will not be able to ensure that their citizens receive necessary health care services.

The state of Texas sought to safeguard the health of its citizens by enacting a statute providing for external review of medical decisions in situations where an MCO has denied a proposed medical treatment as not "medically necessary." Thirty-eight other states and the District of Columbia are also concerned about the impact MCO's utilization review decisions have on their citizens' health and have established some form of external review.[4] The validity of these statutes and the

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[4]2000 Alaska Sess. Laws 99; ARIZ. REV. STATE. ANN. § 20-2537 (West Supp. 1999); CAL. [INS.] CODE § 10169 (West Supp. 2000); COLO. REV. STAT. §10-16-113.5 (West 1999); CONN. GEN. STAT. § 38A-478N (West Supp. 2000); DEL. CODE ANN. Tit. 16, § 9119 (2000); D.C. Code § 32-571.7 (Lexis Supp. 2000); FLA. STAT. ANN. § 408.7056 - 57 (West 2000); GA. Code ANN. § 33-20a-32 (2000); 2000 Haw. Sess. Laws 250; 215 ILL. COMP. STAT. 125/4-10 (West Supp. 2000); IND. INS. CODE ANN. § 27-13-10.1-1 (West 2000); IOWA CODE ANN. § 514J (West 2000); KAN. STAT. ANN. § 40-22A13 (SUPP. 1999); 2000 Kentucky Laws Reg. Sess. 262 (West); LA. REV. STAT. ANN. §22:3081 (2000); 2000 Me. Legis. Serv. 742 (West); MD. CODE ANN. [INS.] §§ 15-10A through 15-10B (Lexis Supp. 1999); 2000 Mass. Legis. Serv. 141 (West); 2000 Mich. Legis. Serv. 251 (West); MINN. STAT. ANN. § 62q.73 (West Supp. 2000); MO. REV. STAT. § 376.1385 (1997); MONT. CODE ANN. §33-37-102b (1999); N.H. REV. STAT. ANN. 420-J:5 (2000); N.J. STAT. ANN. §§ 26:2S-11, 26:2S-12 (West Supp. 2000); N.M. ADM. CODE tit. 13, § 10.17.24 (Michie Supp. 2000); N.Y. [INS.] LAW §§ 4904 (McKinney 1999); N.C. Gen. Stat. §§ 58-50-61, 58-50-62 (1998); OHIO REV. CODE ANN. § 1751.84

ability of states to pass similar statutes is at issue in this case. The states have a vital interest in their ability to protect the public health through the regulation of insurance companies.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case turns on the construction and application of §514 of ERISA to Senate Bill 386, which amended the Texas Insurance Code to provide for a binding, independent physician review of adverse medical necessity determinations made by managed care organizations ("IRO process"). The Fifth Circuit specifically held that the IRO process regulates insurance within the meaning of the savings clause and thus is precluded from preemption. However, in reliance on *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987), the court held that to the extent the law binds an insurer to the decision reached in the independent review, the law is preempted by ERISA §502(a). The offending provisions were severed from the Act. This case presents critical issues regarding the states' ability to regulate health care and insurance, two areas of traditional state oversight. The Fifth Circuit erroneously interpreted *Pilot Life* to mean that the savings clause does not operate if a law provides an alternative remedy for obtaining ERISA benefits. The error resulted from the court's failure to distinguish *Pilot Life* on its facts and to follow applicable authority, such as *UNUM Life Ins. Co. of Am. v. Ward,* 526 U.S. 358 (1999). In addition, the Fifth Circuit's decision conflicts with decisions of

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(Baldwin Supp. 2000); OKLA. STAT. ANN. Tit. 63, § 2528.3 (West 1999); 40 PA. CONS. STAT. §§ 991.2161 *et seq.* (1998); R.I. GEN. LAWS § 23-17.12-10 (Lexis Supp. 2000); 2000 S.C. Acts 380; TENN. CODE ANN. § 56-32-227 (West 1999); UTAH CODE ANN. §31A-22-629 (2000); VT. STAT. ANN. tit. 8, §4089f (1998); VA. CODE § 38.2-5900 to 38.2-5905 (Michie Supp. 2000); 2000 Wash. Legis. Serv. 5 (West); 2000 Wisc. Legis. Serv. 155 (West).

several of its fellow circuits. This conflict among the circuits cannot be resolved without this Court's intervention. Thus, this Court should issue its writ of certiorari to clarify the issues raised in this case and resolve the conflict among the circuits regarding ERISA preemption.

ARGUMENT

I. THIS CASE CONCERNS VITAL ISSUES REGARDING THE STATES' ABILITY TO PROTECT MANAGED CARE CONSUMERS.

This Court should grant certiorari because utilization review laws are critical to the states' oversight of managed care organizations. The Fifth Circuit's interpretation of the savings clause would eliminate the states' ability to effectively regulate health insurance under managed care. Utilization review is one of the central mechanisms used to contain costs under managed care. Utilization review organizations "have mixed clinical and financial functions."[5] Their decisions regarding pre-authorization for high cost medical procedures are widely used by MCOs to reduce costs. *Id.* These decisions concern the unique intersection between quality of care and cost of care, or payment for care through insurance. These two compelling concerns have been historically regulated by the states.

The states have traditionally regulated health care and the business of health care providers. Quality of care is an area of established state regulation--and, in the era of MCOs, of necessary state regulation--and nothing in ERISA indicates that

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[5] Peter D. Jacobson, *Legal Challenges to Managed Care Cost Containment Programs: An Initial Assessment*, Health Affairs (July - August 1999).

"Congress chose to displace general health care regulation."[6] In addition, this Court has recognized that by including the savings clause in ERISA, Congress intended to reserve to the states the right to regulate insurance, another area of traditional state regulation.[7] Therefore, the states should be able to regulate the utilization review process because it concerns two pivotal areas of state regulation -- health care quality and the business of insurance.

Utilization review laws are a matter of profound public concern because they are an effective consumer protection mechanism.[8] They serve an essential function in addressing consumers' concerns regarding underutilization by managed care organizations and reducing litigation over health care decisions. A recent Georgetown University Study[9] found that external utilization review programs are cited as having a sentinel effect on health plans. Furthermore, the study also found that such external utilization review programs are regarded as valuable and fair, with health plan representatives suggesting that such programs helped improve public perceptions about managed care.[10] External reviews are

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[6] *New York Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645, 654-55 (1995).

[7] *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985).

[8] ERISA was enacted to protect consumers--"'to promote the interests of employees and their beneficiaries in employee benefit plans,' ...and 'to protect contractually defined benefits'", *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 113 (1989); *see also* 29 U.S.C. § 1001(b)--and is thus consistent with state consumer protection regulation and remedies.

[9] *External Review Update* at 6.

[10] *Id.*

generally considered universally beneficial to the overall quality of health care in this country.[11] Notably, states with external review laws find that health plans' decisions are overturned in approximately half of the cases reviewed.[12] This reversal rate demonstrates that these laws have a significant impact on the public health.

State legislatures have addressed their citizens' concerns regarding the utilization review process by passing statutes guaranteeing consumers the right to appeal adverse determinations regarding medical decisions to impartial external reviewers. If these laws are not applicable to fully-insured ERISA plans, as the Fifth Circuit held, then the states will be unable to address this crucial concern of their citizens. This Court should grant the petition for writ of certiorari because this case concerns key matters regarding states' rights to regulate health care quality and insurance, areas of historic state regulation.

II. THE FIFTH CIRCUIT MISINTERPRETED *PILOT LIFE* AS REQUIRING PREEMPTION OF SAVED STATE LAWS THAT PROVIDE A STATE LAW CAUSE OF ACTION OR REMEDY.

Although the Fifth Circuit concluded that the IRO process was saved from express preemption by the savings clause, its analysis did not end there. The court also considered whether the IRO process was preempted by §502(a). This analysis was compelled, the court reasoned, by *Pilot Life v. Dedeaux.* The

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[11] Anne Cramer and Erin O'Brien Ide, *The Evolution of Consumer Rights Against Health Plans: External Appeal Process Mandates*, 25 - Vt. B.J. 45 (1999).

[12] *External Review Update, supra* at 5 .

Fifth Circuit noted that in *Pilot Life,* this Court "interpreted Congress's intent regarding the exclusivity of ERISA's enforcement scheme very broadly, concluding that the scheme preempts not only directly conflicting remedial schemes, but also supplemental state law remedies. Thus, the savings clause does not operate if the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan." *Corporate Health,* 215 F.3d 526, 538-39 (5th Cir. 2000), citing *Pilot Life,* 481 U.S. 41 (1987). The court's reliance on *Pilot Life* is misplaced.

A. *Pilot Life* Did Not Involve a State Law Saved by §514(b).

At issue in *Pilot Life* were common law tort and contract claims premised upon the Mississippi law of bad faith. More specifically, the complaint alleged claims for tortious breach of contract, breach of fiduciary duties, and fraud in the inducement. 481 U.S. at 43. The complaint sought extra-contractual damages for failure to pay benefits due under an ERISA regulated plan resulting from improper processing of the petitioner's benefit claim. *Id.* at 48. This Court noted that there was "no dispute that the common law causes of action asserted . . . 'relate to' an employee benefit plan" and that the actions, "each based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for preemption under §514 (a)." *Id.* at 47. "Unless these common law causes of action fall under an exception to §514 (a), therefore, they are expressly pre-empted." *Id.* at 47-48. Dedeaux argued that the Mississippi law of bad faith was a law regulating insurance; thus the claim for tortious breach of contract, which was premised upon that law, was saved from

preemption by §514(b).[13] The question was whether the action came within the savings clause.

This Court concluded that the Mississippi law of bad faith was not a law that regulates insurance. The law did not regulate insurance under a "'common-sense view' of the language of the savings clause itself" because it was not specifically directed at the insurance industry. *Id.* at 50. Rather, the law was derived from general principles of tort and contract law and applied to the breach of any contract, not just insurance contracts. *Id.* at 49-50. In addition, the McCarran-Ferguson Act factors used to identify the business of insurance also failed to support Dedeaux's assertion that the Mississippi law was a law regulating insurance. *Id.* at 50. The conclusion that the action was premised upon a state law expressly preempted by §514(a) and not saved by §514(b) was sufficient to dispose of the case.[14] However, this Court proceeded to consider the United States' contention that the claims were preempted by ERISA's civil enforcement provisions.

Pilot Life's analysis of §502(a)'s preemptive force adopted the Solicitor General's argument, made on behalf of the United States as *amicus curiae.* "The Solicitor General, . . . , argues that Congress clearly expressed an intent that the civil

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[13]Although the complaint contained three counts, the petitioner described only the count for tortious breach of contract (referred to in the respondent's brief as the Mississippi law of bad faith) as being precluded from preemption by §514(b). 481 U.S. at 48.

[14]Because of this, the discussion of §502(a)'s preemptive force is dicta. As the Solicitor General noted in the brief filed in *Unum v. Ward,* "[t]hat portion of *Pilot Life's* rationale is, however, in significant tension with the text of the insurance savings provision and was unnecessary to *Pilot Life's* holding that the law at issue there was not in any event an insurance regulation . . . ." Brief for the United States at 20.

enforcement provisions of ERISA §502(a) be the exclusive vehicle for actions . . . asserting the improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of §502(a) would pose an obstacle to the purposes and objectives of Congress. *We agree.*"[15] *Id.* at 52 (emphasis supplied).

The Solicitor General reasoned that §502(a)'s structure and its legislative history demonstrated Congress' intent for ERISA's remedies to be exclusive. This Court agreed, noting that Congress had "declared that the pre-emptive force of §502(a) was modeled on the exclusive remedy provided under §301 of the Labor Management Relations Act [LMRA]." *Id.* at 52, 54 (citation omitted.) However, it is imperative to note, as this Court does in *UNUM v. Ward,* that the Solicitor General has clarified its position on the preemptive force of §502(a). This clarification sheds light on why the Fifth Circuit erred in modeling its analysis of a state law directed specifically at the insurance industry on *Pilot Life's* analysis of a state law of general application.

In *UNUM v. Ward*, the insurer, relying on *Pilot Life*, argued that the state law was preempted by §502(a). This Court observed that the Solicitor General disagreed with the insurer's position. "Noting that 'LMRA Section 301 does not contain any statutory exception analogous to ERISA's insurance savings provision,' the Solicitor General now maintains that the discussion of §502(a) in *Pilot Life* 'does not itself require that a state law that 'regulates insurance,' and so comes within the terms of the savings clause, is nevertheless preempted if it provides a state-law cause of action or remedy.' " *UNUM v. Ward*, 526 U.S. at 377 n7 (quoting Brief of the United States at 25). This Court, however, declined to revisit *Pilot Life* because

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[15]Citing Brief for the United States at 18-19.

the action in *Ward* was brought under §502(a) of ERISA and sought a remedy under ERISA. Thus, the issue of §502(a)'s preemptive force was not presented. 526 U.S. at 376. However, the discussion of the Solicitor General's clarification of its position in *Pilot Life* suggests this Court might revisit *Pilot Life* in an appropriate case.[16] *Corporate Health* is such a case.

B. The Fifth Circuit's Decision Conflicts with *UNUM v. Ward.*

The Fifth Circuit ignored this Court's decision in *UNUM v. Ward,* a decision requiring a different analysis and a different outcome. The IRO process allows an insured to seek an external, independent review of an insurer's determination that a covered health care service is medically unnecessary. The Fifth Circuit readily acknowledged that the Texas law regulated insurance and was thus saved from preemption by the savings clause. However, the Fifth Circuit characterized the process as "an alternative mechanism through which plan members may seek benefits due them under the terms of the plan--the identical relief offered under §1132(a)(1)(B) [§502(a)(1)(B)] of ERISA." Relying on *Pilot Life*, the court concluded that "the independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the savings clause. *Id.* This holding was not required by *Pilot Life* and is in contrast to the position of the

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[16] "That case [*Pilot Life*] concerned Mississippi common law creating a cause of action for bad faith breach of contract, law . . . not saved from ERISA preemption. *In that context,* the Solicitor General . . . urged the exclusivity of § 502(a) . . . and observed that § 502(a) was modeled on the exclusive remedy provided by § 301. . . . *The Court agreed with the Solicitor General's submission.*" *Ward*, 526 U.S. at 377, n7 (citing *Pilot Life*, 481 U.S. at 52-56) (emphasis supplied).

U.S. Department of Labor.[17] Moreover, it conflicts with this Court's decision in *UNUM v. Ward.*

At issue in *UNUM v. Ward* was the California notice-prejudice rule. The notice-prejudice rule required an insurer to pay claims for benefits that were filed late unless the insurer demonstrated that it was prejudiced by the late filing. The insurer UNUM contended that even if the notice-prejudice rule was saved from preemption by the §514 savings clause, it was nevertheless preempted because it conflicted with §502(a) of ERISA. According to UNUM, §502(a) preempted any action for recovery of plan benefits brought under state rules, such as the notice-prejudice rule. *UNUM v. Ward,* 526 U.S. at 376.

This Court rejected UNUM's position, noting that the action had actually been brought under §502(a) and that the notice-prejudice rule merely supplied the rule of decision in the action. *Id.* at 377. Just as application of the notice-prejudice rule did not transform the §502(a) proceeding into a state cause of action for denial of benefits in *Ward,* application of the decision reached in the IRO process as the rule of decision in a §502(a) action would not transform the proceeding into a state cause of action for denial of benefits.

The Fifth Circuit also failed to consider this Court's analysis of UNUM's argument that the notice-prejudice rule conflicted with §503 of ERISA and related regulations because it allowed a longer period for filing a claim than required by the federal law. 526 U.S. at 377.[18] This Court was not persuaded

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[17]The U.S. Department of Labor filed an amicus brief in *Corporate Health* arguing that the IRO provisions did not conflict with § 502 of ERISA and were not preempted.

[18]UNUM argued that this conflicted with ERISA's "detailed, exclusive provisions governing the filing and processing of ERISA claims," and that

by UNUM's argument. "By allowing a longer period to file than the *minimum* filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulations." *Ward* at 377, citing Brief for United States as *Amicus Curiae* 19 n. 9. Similarly, the Texas IRO process, by mandating a review process that exceeds the *minimum* review mandated by federal law, complements rather than contradicts ERISA and the regulations.[19] It it worth noting that the notice-prejudice rule and the IRO process may have a similar impact on an ERISA plan. In both instances the insurer could be bound to pay a claim it would otherwise have avoided. However, under this Court's decision in *Ward,* neither state law conflicts with ERISA's civil enforcement scheme. The Fifth Circuit's inconsistent decision should be reviewed by this Court.

ERISA's enforcement scheme would be "'completely undermined if ERISA-plan participants' . . . could use state law doctrines to obtain benefits contrary to the plan's written terms and ERISA's civil enforcement scheme." Petition for Certiorari at 25, quoting from *Pilot Life v. Dedeaux,* 481 U.S. at 54.

[19]ERISA requires plans to provide notice and the opportunity for review of denied claims. §503 of ERISA, 29 U.S.C. §1133. In the implementing regulations, the Department of Labor merely "sets out certain *minimum* requirements for employee benefit plan procedures pertaining to . . . review of claim denials." 29 C.F.R. § 2560.503-1(a) (emphasis added).

III. THE FIFTH CIRCUIT'S DECISION CONFLICTS WITH DECISIONS OF THE SEVENTH, SECOND AND THIRD CIRCUITS.

A. The Seventh Circuit Held that the IRO Provisions Did Not Conflict With a Substantive Provision of ERISA.

The Fifth Circuit's decision conflicts with a recent decision of the Seventh Circuit. The Seventh Circuit considered the Illinois independent review law, a law similar to the Texas law. The Illinois law requires that health maintenance organizations ("HMOs") provide a mechanism for independent review of treatment decisions regarding medical necessity.[20] *See* 215 Ill. Comp. Stat. Ann. 125/4-10 *et seq*. (West Supp. 2000). The court held the Illinois law was not preempted by ERISA because the Illinois independent review law fell within the ERISA savings clause. *Moran v. Rush Prudential HMO*, 2000 WL 1551659. The court was also satisfied that the law did not conflict with § 502(a) as it "is not tantamount to the relief offered under § 502(a)(1)(B)." *Id.* at *11. Instead, the independent review law "simply adds to the contract, by operation of law, an additional dispute resolving mechanism . . ." *Id.*

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[20]In *Moran*, the plaintiff's primary care physician recommended a specific surgery, but her HMO (Rush Prudential) decided the procedure was not medically necessary and authorized a less expensive surgery to be carried out by one of its affiliated doctors. 2000 WL 1551659 at *2. The plaintiff proceeded with the surgery recommended by her physician and afterwards sought to enforce her rights in state court under the Illinois independent review law. *Id.* at *3. Rush Prudential removed the action to federal district court on ERISA preemption grounds. *Id.* at *4.

The Seventh Circuit was correct in finding no substantive conflict between the IRO provisions and ERISA. The IRO process does not provide the identical relief offered under § 502 (a). ERISA does not expressly (or implicitly) guarantee a right to independent review of medical necessity determinations. There was no basis for the Fifth Circuit's conclusion that the Texas law conflicts with ERISA because it provides the same relief offered under § 502(a). *Corporate Health*, 215 F.3d at 539. The Seventh Circuit's decision in *Moran* is in direct conflict with the Fifth Circuit's decision in *Corporate Health* on this point.[21] The Supreme Court should grant a writ of certiorari in order to resolve the conflict between the Fifth and Seventh Circuits.

B. The Second and Third Circuits Have Correctly Held That State Insurance Laws Can be Enforced in State Court Actions.

The Second and Third Circuits have not interpreted *Pilot Life* as a bar to saving state insurance laws from preemption or an obstacle to enforcement of those laws. In *Franklin H. Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d. 144 (2nd Cir. 1995), the Second Circuit appropriately distinguished *Pilot Life* and other cases by finding that those decisions "involve statutes that, while impacting on the insurance industry, are based upon general contract and tort principles." *Id.* at 150.

The state law at issue in *Williams Trust* required that interest on proceeds of a life insurance policy be computed

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[21]The Seventh Circuit recognized that their decision conflicted with the opinion of the Fifth Circuit in *Corporate Health*, and therefore circulated the decision among all judges of the court to determine whether to rehear the case *en banc*. The Seventh Circuit voted not to rehear the case *en banc*. The dissent noted that "[t]he panel's decision creates a square conflict . . ." with the Fifth Circuit. 2000 WL 1551659 at *13.

from the day of death. *Id.* at 146. The Second Circuit followed this Court's reasoning in *Metropolitan Life* and applied a "common sense test" to the state law. Quoting *Metropolitan Life*, the Second Circuit said simply that "to state the obvious, [the state law] regulates the terms of certain insurance contracts, and so seems to be saved from preemption by the savings clause as a law 'which regulates insurance.'" *Id.* at 149, (citing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 740.

The Second Circuit found that the state law at issue was similar to the statute addressed in *Metropolitan Life* "and [was] precisely the type of statute Congress intended to save from ERISA preemption." *Id.* In *Metropolitan Life* the statute at issue provided for a substantive right to mental health care and in *Williams Trust* the statute regulated the payment of interest on benefits - both laws having similar effects as the independent review law at issue here. The Second Circuit further held that ERISA was not the sole means of enforcing the state law, as "[i]t would be quixotic to rule that a claim under a state statute that is saved from preemption ... may nonetheless be enforced only via ERISA provisions and remedies."[22] *Id.* at 151. If the savings clause precludes preemption of a state insurance law, then it follows that both the substantive state law and the state law remedial measures required to give the law effect are saved.

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[22]The Solicitor General supports this view. In clarifying the position taken in *Pilot Life*, the Solicitor explained that Congress "clearly intended the remedial provisions of ERISA to be exclusive of any *generally applicable* state-law remedies related to ERISA plans. It does not follow, however, that ERISA Section 502 should inform the preemption inquiry to the same extent with respect to a state law cause of action or remedy that specifically 'regulates insurance' . . . . In that situation Congress has saved state substantive law, and it is not clear why Congress would have wanted to foreclose all access to state-created remedies or sanction to enforce that substantive law . . . ." Brief for the United States in *UNUM v. Ward* at 22.

The Third Circuit in *Pas v. Travelers Ins. Co.*, 7 F.3d 349 (3rd Cir. 1993), held that a state law providing a remedy for discrimination against certain handicapped persons (in insurance contracts) was not preempted by §502(a). Travelers argued that the state law was preempted because it created a cause of action that conflicted directly with the federal cause of action under ERISA § 502(a). *Id.* at 356. The Third Circuit analyzed whether there was an actual conflict between ERISA and the state law. The court observed that preemption occurs when a state law "purports to provide a remedy for the violation of a right expressly guaranteed by [a section of ERISA] and exclusively enforced by §502(a) [of ERISA.]." *Pas*, 7 F.3d at 356 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 145 (1990). Because ERISA does not expressly guarantee the right provided under the New Jersey law, the court concluded that a "necessary requirement" for conflict preemption was missing. *Id.*

The Second and Third Circuit's reasoning is correct. The express preemption scheme in ERISA should be applied. Under a plain reading of the statute, § 502 is subject to the savings clause. The savings clause provides that "nothing in this subchapter [which includes § 502] shall be construed to exempt or relieve any person from any law of any State which regulates insurance..." 29 U.S.C. § 1144(b)(2)(A). Therefore, § 502 should not be construed to invalidate state insurance laws. Furthermore, the IRO provisions do not conflict with any substantive provisions of ERISA. Instead, they compliment ERISA by specifying minimal qualifications - such as being independent of the health plan - that a person making the final decision regarding whether a treatment is medically necessary

must have. Therefore they serve the same purpose as ERISA, that is to protect beneficiaries in employee benefit plans.[23]

The Fifth Circuit's decision is in direct conflict with the Second and Third Circuits' decisions on this issue. The *Pas* court acknowledged that other appellate court decisions conflict with its interpretation, which merely emphasizes the need for clarification of the scope of § 502(a) by this Court.

IV. CIRCUITS HOLDING THAT STATE INSURANCE LAWS MAY ONLY BE ENFORCED IN A § 502(a) PROCEEDING ARE INCORRECT.

Several Circuits have incorrectly interpreted *Pilot Life* to require state insurance laws to be enforced through a § 502 action under ERISA. This was the Seventh Circuit's conclusion in the *Moran* case. The court concluded that although §502(a) did not preempt the Illinois independent review law, §502(a) was the "sole launching ground" for claims arising from the Illinois independent review law. 2000 WL 1551659 at *11.

The Sixth, Eighth and Ninth Circuits have similarly held that state insurance laws may only be enforced in a §502 proceeding. In *Ruble v. UNUM Life Ins. Co.*, the Sixth Circuit stated, "Regardless of how Michigan's insurance code might have modified the terms of the UNUM insurance policy, however, any action brought by a beneficiary to enforce the policy as so modified could only be brought under §502 of ERISA." 913 F.2d 295, 297 (6th Cir. 1990) (citation omitted). And the Eighth Circuit in *Donatelli v. Home Ins. Co.*, 992 F.2d

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[23] "In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989).

763, 764-65 (8th Cir. 1993), held that the Missouri "suicide law" could not be enforced by way of a state-law breach of contract action, but it could be asserted in a §502(a) proceeding as governing the interpretation of the insurance policy's terms concerning payment of claims in cases of suicide. In *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 493-94 (9th Cir. 1988), the Ninth Circuit held that a provision of the California Insurance Code providing for compensatory and punitive damages arising from delay in claims payment was preempted by ERISA pursuant to *Pilot Life*, even if the law was a law regulating insurance under the savings clause.

Circuits that have held that insurance statutes may only be enforced through a § 502(a) action are incorrect. These courts have misconstrued this Court's holding in *Pilot Life*. The savings clause explicitly states Congress's intent to save from preemption state insurance laws that relate to an ERISA plan. Nothing in the language of the savings clause, or in the legislative history, suggests that Congress intended that state insurance laws may be enforced only in a §502 (a) proceeding. The Fifth Circuit's decision presents an opportunity for this Court to address this issue.[24] The interplay between the savings clause in §514 and the civil enforcement provisions in §502 is the subject of increasing conflict among the circuits. The petition for certiorari should be granted so that this Court can bring clarity to a matter of national importance.

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[24]In *Ward*, this Court declined to address the insurer's argument that §502 (a) is the "sole launching ground" for an action to enforce a saved state insurance law because the action was brought under §502(a).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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No. 00-665

In The

Supreme Court of the United States

JOSE MONTEMAYOR, COMMISSIONER OF THE TEXAS DEPARTMENT OF INSURANCE; JOHN CORNYN, ATTORNEY GENERAL OF TEXAS,

Petitioners,

v.

CORPORATE HEALTH INSURANCE, INC.; AETNA HEALTH PLANS OF TEXAS, INC.; AETNA HEALTH PLANS OF NORTH TEXAS, INC.; AETNA LIFE INSURANCE COMPANY,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

MOTION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE AMERICAN MEDICAL ASSOCIATION AND THE TEXAS MEDICAL ASSOCIATION IN SUPPORT OF THE PETITIONERS

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MOTION OF AMERICAN MEDICAL ASSOCIATION AND TEXAS MEDICAL ASSOCIATION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

Pursuant to Sup. Ct. Rule 37.2(b), *Amici Curiae* the American Medical Association ("AMA") and the Texas Medical Association ("TMA") move this Court for leave to file the accompanying brief.

As two of the nation's largest associations of physicians, the AMA and the TMA can offer this Court a unique perspective on the public health issues implicated by the instant appeal, including an analysis of applicable health policy issues. The AMA and the TMA further seek to inform this Court of the associations' internal policies and opinions relevant to this case. The AMA and the TMA believe that the United States Court of Appeals for the Fifth Circuit errantly disposed of issues critical to this appeal, and *amici* wish to address public health concerns that are relevant to the proper resolution of those issues.

The AMA/TMA have been unable to secure the consent of Respondents to the filing of their brief.

Respectfully submitted,

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STATEMENT OF INTEREST

Amicus the American Medical Association ("AMA"), an Illinois not for profit corporation, is an association of approximately 300,000 physicians who practice throughout the United States. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these still remain its core purposes. Its members practice in all fields of medical specialization, and it is the largest medical society in the United States.[1]

Amicus Texas Medical Association ("TMA"), a Texas not for profit corporation, is an association of physicians who practice in the State of Texas. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its maxim continues in the same direction: "Physicians Caring for Texans." Its approximately 36,000 members, representing more than 83% of all licensed physicians in Texas, practice in all fields of medical specialization. As an association of physicians and medical students, TMA is interested in and concerned with matters before this Court which affect the health of the citizens of Texas.[2]

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[1] Counsel for the AMA authored this brief in its entirety. No monetary contributions to the preparation or submission of this brief were received from any source other than the AMA/State Medical Society Litigation Center. Sup. Ct. R. 37.6.

[2] *Amici* file this brief as members of the American Medical Association/State Medical Society Litigation Center ("Litigation Center"). The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts.

The membership of the AMA and the TMA are devoted to securing the best possible medical care for their patients. They promote a health care environment in which adequate medical care is available for all, regardless of the ability or inability to pay for that care. The holding of the United States Court of Appeals in *Corporate Health Insurance, Inc. v. Texas Dept. of Insurance*, 215 F.3d 526 (5th Cir. 2000), *rehearing denied*, 220 F.3d 641 (2000), impacts the accessibility of satisfactory medical care, thereby raising issues of significant interest to the AMA and the TMA.

In the considered opinion of the AMA and the TMA, the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001, *et seq.* (1999)) ("ERISA"), is frequently applied so as to impede uniform access to adequate medical care. Rather than limiting ERISA to the administrative purposes for which it was intended, some courts, including the Fifth Circuit Court of Appeals in this case, extend ERISA's reach beyond the scope intended by its drafters, and declare that ERISA preempts laws more properly reserved to a state's sovereign power. By finding that ERISA preempts an independent, external review of a denial of medical benefits, the Fifth Circuit frustrated Texas' legitimate attempt to regulate medical care rendered to its citizens. The Texas Health Care Liability Act (Act of May 22, 1997, 75th Leg., R.S., ch. 163, § 1, 1997 Tex. Gen. Laws 317) ("THCLA") is an enlightened legislative effort to ameliorate the potentially devastating consequences of an improper denial of medical insurance benefits. THCLA is an important adjunct to the services that *amici's* members provide to their patients and, consequently, furthers the interests of public health.

For these reasons, *amici* support the Petition for *certiori* filed by Petitioners Jose Montemayor, Commissioner of the Texas Department of Insurance and John Cornyn, Attorney General of Texas ("Petitioners"). *Amici* endorse the arguments made in Petitioners' brief. *Amici* urge the Court to grant a writ of *certiorari* so that the Court may resolve the important issues raised by this appeal.

SUMMARY OF ARGUMENT

Members of the AMA and the TMA dedicate themselves to promoting the best interests of their patients, including the patients' interests as recipients of health care benefits. *Amici's* members view with alarm the increasing tendency of health care insurers to place their pecuniary well-being ahead of adequate medical care for health plan beneficiaries. One of the inequities routinely faced by health care consumers is a system of benefit determination which is controlled solely by insurers and which offers no meaningful method for beneficiaries to appeal a denial of benefits. Therefore, *amici* encourage legislation allowing patients access to an independent, external review system to contest denials of health care benefits.

The Fifth Circuit's decision in *Corporate Health Insurance, Inc. v. Texas Dept. of Insurance*, 215 F.3d 526 (5th Cir. 2000), *rehearing denied*, 220 F.3d 641(2000), undermines a legislative attempt to rectify an imbalance in our health care delivery system. In *Corporate Health*, the Fifth Circuit reviewed a challenge by private health care insurers to the Texas Health Care Liability Act (Act of May 22, 1997, 75th Leg., R.S., ch. 163, § 1, 1997 Tex. Gen. Laws 317)), which amended the Texas Insurance Code to create an Independent Review Organization (TEX. INS. CODE arts. 20A.12A, 21.58A, § 2(3)) ("IRO"). The IRO provisions establish a mechanism by which patients can appeal an "adverse determination", defined as:

> "[A] determination by [an HMO] or utilization review agent that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary or are not appropriate." TEX. INS. CODE art. 20A.12(c)(1).

The insurers alleged, *inter alia*, that certain portions of the law were preempted by the Employee Retirement Income Security Act 29 U.S.C. § 1001, *et seq.* (1999) ("ERISA"). The Fifth Circuit ruled that pertinent portions

of the IRO were preempted, because the review provisions "conflict with [Section 502(a),] a substantive [remedial] provision of ERISA." *Id.* at 539.

The *Corporate Health* opinion ignores the common sense arguments and objective data illustrating the need for an independent grievance review process. By finding the IRO preempted by ERISA, moreover, the Fifth Circuit extended the statute's preemptive reach well beyond the boundaries intended by the drafters of ERISA. This Court has made clear that ERISA regulates the administration of health and welfare benefit plans but was never intended to stifle a state's right to regulate, through statute or common law, substantive areas of law reserved to the state, such as standards governing the quality of medical care dispensed within the state. Nonetheless, the Fifth Circuit strayed beyond the intended parameters of ERISA preemption, and held that the federal statute preempted the state's right to regulate the quality of medical care rendered within Texas. This Court's intervention is needed to correct this error.

Amici also urge the Court to grant *certiorari* to resolve a conflict among the federal circuit courts, namely, whether independent review provisions like the one construed by the Fifth Circuit conflict with the remedies set forth in ERISA and, therefore, are preempted by ERISA. In *Corporate Health*, the Fifth Circuit held that a conflict existed, and found the IRO preempted. In *Moran v. Rush HMO*, 2000 U.S. App. Lexis 26053 (7th Cir. October 19, 2000), the Seventh Circuit Court of Appeals recently construed a virtually identical scheme enacted by the Illinois legislature and found no ERISA preemption. Should this Court fail to grant *certiorari*, the disparity between the decisions of the Fifth and Seventh Circuits will make enforcement of similar independent review provisions adopted by 33 other states and the District of Columbia

capricious, rather than uniform.[3] The lower courts and state legislatures look to the Court to resolve this dilemma.

Additionally, the *Corporate Health* decision highlights issues yet unresolved within this Court's own opinions. In *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987) (*"Pilot Life"*), the Court held that a state law that conflicts with the exclusive remedies prescribed by Section 502(a) of ERISA (29 U.S.C. § 1132(a)) must yield to ERISA preemption. In *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (*"Ward"*), however, the Court indicated that a state law "saved" from ERISA preemption because it regulates insurance will, by virtue of ERISA's savings clause, not be preempted regardless of any conflicts with the remedial provisions of ERISA. Nonetheless, the issue of whether the

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[3] 2000 Alaska Sess. Laws 99, ARIZ. REV. STAT. ANN. § 20-2537 (West Supp. 1999), CAL. [INS.] CODE § 10169 (West Supp. 2000), COLO. REV. STAT. § 10-16-113.5 (West 1999), CONN. GEN. STAT. § 38a-478n (West Supp. 2000), DEL. CODE ANN. tit. 16, § 9119 (2000), D.C. CODE § 32-571.7 (Lexis Supp. 2000), 2000 Fla. Laws ch. 00-256 (West), GA. CODE ANN. § 33-20A-32 (2000), 2000 Haw. Sess. Laws 250, 215 ILCS 125/4-10 (West Supp. 2000), IND. INS. CODE ANN. § 27-13-10.1-1 (West 2000), IOWA CODE ANN. § 514J (West 2000), KAN. STAT. ANN. § 40-22a13 (Supp. 1999), 2000 Kentucky Laws Reg. Sess. 262 (West), LA. REV. STAT. ANN. § 22:3081 (2000), 2000 Me. Legis. Serv. 742 (West), MD. CODE ANN. [INS.] §§ 15-10A through 15-10B (Lexis Supp. 1999), 2000 Mich. Legis. Serv. 251 (West), MINN. STAT. ANN. § 62Q.73 (West Supp. 2000), MO. REV. STAT. § 376.1385 (1997), MONT. CODE ANN. § 33-37-102 (1999), N.H. REV. STAT. ANN. 420-J:5 (2000), N.J. STAT. ANN. §§ 26:2S-11, 26:2S-12 (West Supp. 2000), N.M. ADM. CODE tit. 13, § 10.17.24 (Michie Supp. 2000), N.Y. [INS.] LAW § 4904 (McKinney 1999), N.C. GEN. STAT. §§ 58-50-61, 58-50-62 (1998), OHIO REV. CODE ANN. § 1751.84 (Baldwin Supp. 2000), OKLA. STAT. ANN. tit. 63, § 2528.3 (West 1999), 40 PA. CONS. STAT. § 991.2162 (1998), R.I. GEN. LAWS § 23-17.12-10 (Lexis Supp. 2000), 2000 S.C. Acts 380, TENN. CODE ANN. § 56-32-227 (West 1999), UTAH CODE ANN. § 31A-22-629 (2000), VT. STAT. ANN. tit. 8, § 4089f (1998), VA. CODE § 38.2-5900 to 38.2-5905 (Michie Supp. 2000), 2000 Wash. Legis. Serv. 5 (West), 2000 Wisc. Legis. Serv. 155 (West).

savings clause in ERISA "trumps" the remedial provisions of Section 502(a) of ERISA was not squarely addressed in *Ward*. *Corporate Health* now brings that issue before this Court, making resolution of the issue appropriate.

ARGUMENT

I. The Texas Legislation Satisfies A Pressing Need In Our Health Care System That Should Not Be Preempted By ERISA

For the last several years, *amici* have advocated the need for external, independent review of denials of health care benefits. The AMA endorses legislation "to provide that ERISA does not preempt a state's jurisdiction over the quality of medical services delivered when the state regulates managed care organizations making medical necessity decisions for covered medical services." American Medical Association, *Policy Compendium* H-165.875 at 308 (1999) ("*Policy Compendium*").[4] The AMA seeks to strengthen the health care system for patients and physicians by promoting policies that make patients and the physician/patient relationship superior to any other concern. *Policy Compendium*, H-165.895 at 312. To this end, the AMA will target, among other things, "insurance reform." *Id.* In its policy H-165.892, the AMA "encourages and supports federal legislation . . . including the necessary ERISA . . . waivers, to allow states to pursue health system reform at the state level." *Policy Compendium*, H-165.892 at 312. In 1996, the AMA pledged that it would, through amendment to ERISA and through enactment of state and federal legislation, seek regulation of self-insured insurance plans to ensure that they were

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[4] H-165.875 refers to policy 165.875, as adopted by the AMA House of Delegates, the AMA's principal policy-making body. AMA policies can be found at www.ama-assn.org/apps/pf-online.

regulated "in regard . . . to appeals and grievance procedures." *Policy Compendium,* H-165.883 at 310.

Several considerations drive *amici's* interest in accountability by health care insurers. The interpretation and application of ERISA affects hundreds of millions of people. As noted by the General Accounting Office in 1998, "[m]ost workers and their families in the private sector receive their health insurance coverage through employers . . . [A]bout 125 million people receive health insurance through about 2.5 million employer-based health care plans covered by ERISA." United States General Accounting Office, Employer-Based Managed Care Plans: ERISA's Effect on Remedies for Benefit Denials and Medical Malpractice at 6 (July 1998) ("GAO"). Thus, this Court's resolution of the interplay between ERISA preemption and independent benefit review will have far-reaching consequences.

Further, although ERISA-controlled health plans are, by definition, sponsored by employers, they are not an entirely free benefit of employment. Employees pay a premium to obtain health care insurance from the plan. In turn, the health plan is bound to provide health care as promised by the plan as a self-insured entity, or by a third-party insurer with whom the employer has contracted. *Id.* at 5; 29 U.S.C. § 1022 (1999). Patients are therefore entitled to receive the benefits for which they have paid. Additionally, if a request for coverage is denied by an insurance company that drafted the terms of the contract, and the beneficiary is allowed no right of recourse, general insurance principles suggest that any ambiguities concerning the breadth of medical coverage available to the plan participant shall be construed against the insurer. See Long, *The Law of Liability Insurance* 16-39 (1984); Mehr & Cammack, *The Principles of Insurance* 162 (6th ed. 1976).

When, as in this case, benefits can be denied as being "medically unnecessary", the presumption of unfairness to the health care consumer is even stronger. A benefit determination grounded in medical necessity suggests

that only a licensed physician is qualified to grant or deny benefits. Timothy T. Flaherty, MD, Statement of the American Medical Association to the Subcommittee on Employer-Employee Relations, Committee on Education and the Workforce, U.S. House of Representatives at 3 (April 20, 1999) ("Flaherty Statement"). Regardless, some insurers employ non-physicians to make benefit decisions grounded in medical necessity. *Id.* at 3. Combined with the fact that benefit decisions are often motivated by the insurer's pecuniary interest, and not the beneficiary's medical interest (Richard F. Corlin, MD, Statement of the American Medical Association to the Committee on Health, Education, Labor and Pensions, United States Senate (March 2, 1999)), the denial of benefits becomes immediately suspect. The only way to guarantee that the insurer fulfils its contractual obligation to provide medically necessary care to plan participants is to subject contested decisions to an external reviewer, qualified in the medical specialty at issue, and with no financial ties to the insurer. Before the United States House of Representatives Sub-Committee of Employer-Employee Relations, Timothy Flaherty, MD, Secretary-Treasurer of the AMA Board of Trustees testified:

> "The absence of independent review enables plans to make unfair and arbitrary decisions with virtually no consequences. Patients who are denied access to necessary care are then forced to pay out-of-pocket for necessary medical service, which may in fact be covered services. More important, patients who are forced to forego necessary care awaiting the real outcome of a coverage or medical necessity dispute may suffer real, sometimes irreversible harm." *Id.* at 2.

Additionally, the enactment of ERISA predated the shift in this country from predominantly fee-for-service medical care to the managed care environment that dominates the medical landscape today. GAO at 1. Pursuant to traditional fee for service care, patients were provided

direct access to their physicians and payment issues were addressed after treatment. Today, however, health plans generally require that coverage decisions must be decided before medical service will be provided. "Thus, under today's health plan structure, a denial of a claims equates to a denial of benefits, especially for those who cannot afford to pay out of their pockets." Flaherty Statement at 4.

Amici are aware of this Court's recent announcement that it has no intention of dismantling managed care as it currently exists. *Pegram v. Herdrich*, ___U.S.___, 120 S. Ct. 2143, 2150-51 (2000). Neither AMA nor TMA advocate such a dramatic result in this case. However, the associations urge the Court to consider the benefits to consumers and to the health care industry that will result should the Court grant *certiorari* in this case, and on the merits, interpret ERISA as *amici* contend it was intended to be interpreted. In a 1997 study, the Lewin Group found that the existence of fair and impartial decision-makers gave consumers greater confidence in their health care plans and coverage. The Lewin Group, *Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals* at 31 (November 18, 1997). By increasing an insurer's accountability through an independent reviewer, moreover, consumers have more leverage in dealing with the insurer. *Id.* at 32. The study also predicted that the existence of effective external review procedures would reduce the number of challenges to benefit denials in the courts, and would motivate health plans to consider benefit determinations with greater care, in order to avoid the external appeal process. *Id* at 31.

A 1998 study by The Kaiser Family Foundation compared the external review programs available through Medicare and in thirteen states. Karen Pollitz, Geraldine Dallek, Nicole Tapay, *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare* (The Kaiser Family Foundation, November 1998). While the programs were different in several ways,

the researchers also found "striking similarities in many respects." *Id.* at 5. The study found, for example, parity between the number of plan decisions affirmed and reversed by independent reviewers: "Across all programs studied, external review overturned health plan decisions between one third and two thirds of the time." *Id.* These results increased the trust of the regulated companies that they would receive a fair hearing before the reviewer. *Id.* at 6. Moreover, the costs of external review were relatively low, particularly when compared to the costs of standard litigation. In all but one of the states studied, the cost of external review was $500 or less. *Id.* Medicare cases subject to external review cost $300. *Id.*

Independent review procedures were also regarded as having a "sentinel" effect on health plan behavior. *Id.* at 6. In other words, health plans learned from the external review processes, and came to understand what decisions independent reviewers were likely to reverse, and which ones would not be reversed. As a consequence, requests for review of denial of a particular form of care tended to decline with time, as the plan came to understand the state's expectations. *Id.* Critically, too, the study found even that health care insurers had high regard for the external review processes:

> "Regulators, external review agency staff, and industry representatives alike reached this conclusion about the process. The fact that the disposition of external review equally favored consumers and plans was cited as both an indication of the need for the process as well as evidence of its objectivity and creativity. . . . Several experts also noted that the growing number of private health plans voluntarily submitting to external review could be interpreted as a vote of confidence in the external review process. Health plan industry representatives suggested that the external review process

helped improve public perceptions about managed care and reduced the need for health plan liability laws." *Id.* at 6-7.

The fact that health care insurers realize benefits from external review processes only increases the urgency of the need for this Court to grant *certiorari* in this appeal. Independent review of health care benefit denials are needed to safeguard the public health and to buttress public confidence in the managed care system. If permitted to stand, the precedent set by the *Corporate Health* opinion will harm health care consumers and impede positive aspects of the managed care system that this Court believes should be perpetuated.

II. The Fifth Circuit Neglected To Follow *Travelers*, *Pegram* And Other Supreme Court Authorities On Eligibility Decisions That Require Determinations Of Medical Necessity Or Appropriateness

Amici's conclusion that independent review procedures can directly impact public health highlights a core misapprehension of the Fifth Circuit's holding in *Corporate Health*. In ruling that the remedial provisions of ERISA's Section 502(a) preempted the IRO law, the Court errantly extended the preemptive authority of ERISA and improperly impinged upon Texas' sovereign right to dictate standards of medical care for its citizenry. Specifically, the Fifth Circuit ignored Supreme Court cases stating that ERISA does not, and is not intended to, preempt a state exercise of power in substantive areas traditionally reserved to state sovereignty.

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 115 S. Ct. 1671, 131 L.Ed. 2d 695 (1995) (*Travelers*), this Court construed state legislated surcharges levied against hospital patients insured by commercially owned insurance companies. The plaintiff insurance companies sued officials of the State of New York, alleging that the state scheme

"related to" employee benefit plans subject to ERISA, and as a consequence, was preempted by ERISA.

The Court found the plaintiffs' argument meritless. *Travelers*, 514 U.S. at 661. The Court ruled that the "relation" suggested by the plaintiffs was too tenuous to withstand scrutiny. Moreover, the Court stated that "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 661; see also *California Division of Labor Standards Enforcement v. Dillingham Construction N.A. Inc.*, 519 U.S. 316 (1997); *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997).

In *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000), the Court again addressed the interaction of a state's authority to regulate medical care dispensed within its borders, and the breadth of the ERISA statute's reach. In *Pegram*, Herdrich received treatment from Dr. Pegram, a physician owner of the Carle Clinic, an HMO. Herdrich alleged that Pegram delayed necessary medical treatment for Herdrich. From these facts, Herdrich attempted to plead a breach of fiduciary duty under ERISA against Carle.

The Court held that plaintiff failed to plead a breach of fiduciary duty, as stated in ERISA. *Pegram*, 120 S. Ct. at 2155-56. The Court observed that the fiduciary duties encompassed by the ERISA statute include acting as a manager, administrator or financial advisor to a benefits plan. *Pegram*, 120 S. Ct. at 2151. By contrast, the allegations of Pegram's complaint implicated both a determination of eligibility for benefits under the benefits plan, and matters concerning medical treatment.

The Court concluded that mixed treatment/eligibility determinations are not fiduciary in nature. *Id.* at 2155. In each instance where a plaintiff claimed that an HMO physician breached his fiduciary duty in reaching a mixed eligibility/treatment decision, the finder of fact would have to refer to standards of reasonable and customary medical practice. A fiduciary obligation encompassing mixed determinations, therefore, would merely

replicate state malpractice claims. *Id.* at 2158. The Court further recognized that subsuming malpractice standards into ERISA fiduciary responsibilities created a possibility that state malpractice claims could be preempted by ERISA. *Id.* The Court rejected this possibility, stating: "[W]e know that Congress had no such haphazard boons in prospect when it defined the ERISA fiduciary, nor such a risk to the efficiency of federal courts as a new fiduciary-malpractice jurisdiction would pose in welcoming such unheard-of fiduciary litigation." *Id.*

In this case, the Fifth Circuit construed a provision of the Texas insurance code which prescribed independent review for denial of benefits when the denial was grounded in "medical necessity" or "appropriateness". *Corporate Health*, 215 F.3d at 537. Under *Pegram*, "medical necessity" determinations require the exercise of medical judgment and thus, inherently, are determinations that mix benefit eligibility considerations with medical decision making. *Pegram*, 120 S. Ct. at 2155.[5]

Congress did not intend to extend the power of ERISA into the arenas covered by mixed treatment/eligibility decisions. *Id.* at 2156; *see also Managed Care Liability Update*, 6 Health Plan and Provider Report (BNA) No. 32, at 979-91 (Aug. 9, 2000). (Analysis of Federal HMO Act (42 U.S.C. § 300e, *et seq.*), which was enacted the year before Congress passed ERISA, indicates that Congress intended the states to regulate "medical necessity" determinations and that Congress deliberately rejected federal regulation of quality of care, so that those decisions could rest with the states). *Amici* respectfully suggest that the Fifth Circuit erred when it concluded that the review provisions substantively conflicted with the enforcement provisions of ERISA. Therefore, independent review of

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[5] Indeed, the *Pegram* Court expressly mentioned the "medical necessity requirement that conditions the HMO's obligation to . . . pay for that particular procedure" as a type of eligibility decision that "cannot be untangled from physicians' judgments about reasonable medical treatment." *Id.* at 2154.

benefit decisions involving medical necessity or appropriateness are not preempted by ERISA.

III. Review By This Court Is Necessary To Resolve Conflicts In ERISA Caselaw And To Bring Predictability To Efforts To Secure Safeguards For Adequate Healthcare

Petitioners have thoroughly explained how the Circuits conflict in their interpretation and application of the ERISA statute. In light of the excellent arguments articulated by Petitioners, and mindful of this Court's admonition in Supreme Court Rule 37(a), AMA/TMA will not belabor points already made concerning the present confusion in ERISA interpretation. *Amici* do contend, however, that a recent decision of the Seventh Circuit Court of Appeals, directly at odds with the holding of the Fifth Circuit, not only illustrates a material disagreement among federal appellate courts, but also reveals an underlying conflict among this Court's ERISA-based decisions. Resolution of this conflict is urgently required so that AMA/TMA and anyone else interested in safeguarding basic medical rights can draft effective legislation, not subject to ERISA preemption.

In *Corporate Health*, the IRO construed by the Fifth Circuit allows patient appeals of "adverse determinations" of medical coverage, meaning, a denial by the benefit provider of health care coverage because the insurer found the requested coverage inappropriate or not medically necessary. *Corporate Health*, 215 F. 3d at 537. The Fifth Circuit first determined that the law was not preempted under Section 514 of ERISA. Whether the law "related to" ERISA pursuant to Section 514 was not determinative; as a state law regulating insurance, it was exempt from preemption under Section 514's "savings clause". *Id.* at 538. However, the Fifth Circuit ruled next that the IRO conflicted with, and thus was preempted by, the terms of Section 502(a) of ERISA. *Id.* at 539. Section 502(a) enumerates the remedies available for violation of

the statute. Relying primarily on *Pilot Life Ins. v. Dedeaux*, 481 U.S. 41 (1987) (*"Pilot Life"*), the Fifth Circuit viewed the independent review procedures of the Texas statute as an "alternative mechanism through which plan members may seek benefits due them under the terms of the plan – the identical relief offered under [Section 502(a)] of ERISA. As such, the independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the savings clause." *Id.*

Interpreting a section of the Illinois HMO Act virtually identical to the Texas IRO law, the Seventh Circuit Court of Appeals reached the opposite conclusion. In *Moran v. Rush HMO*, 2000 U.S. App. LEXIS 26053 (2000), a majority of a divided Seventh Circuit court held that ERISA did not preempt Section 4-10 of the HMO Act, the authority pursuant to which *Moran* asserted her claim. Like the Fifth Circuit in *Corporate Health*, the Seventh Circuit found the independent review law satisfied the savings clause test, and therefore escaped preemption as a law that relates to plan administration. *Id.* at *8-9. Unlike the IRO in *Corporate Health*, however, the Seventh Circuit found no conflict between the review provisions of Section 4-10 and the ERISA remedies set forth in Section 502(a). *Id.* at *10.[6]

Instead, the court relied on this Court's decision in *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (*"Ward"*), and stated that statutory insurance provisions like Section 4-10 are incorporated into contracts of insurance and become substantive provisions of the contract. *Id.* In *Moran*, the Court continued, the benefit plan is an insurance contract. Because the provisions of Section 4-10 have

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[6] The disagreement over the proper interpretation of independent review provisions runs not just between the circuits. Four judges of the Seventh Circuit voiced objection to the majority's holding. The dissent stated that "[t]he panel's decision creates a square conflict with another circuit . . . and will affect an enormous number of cases." *Moran v. Rush HMO*, 2000 U.S. App LEXIS at *12 (Posner, J., dissenting).

been incorporated into the plan, a suit by Moran to "enforce [Section 4-10] is simply a suit to enforce the terms of the plan – precisely the sort of suit that is contemplated under Section 502 . . . to 'enforce rights' and 'recover benefits' under the plan." *Id.* The HMO Act did not provide an alternative, conflicting remedy for Moran to recover benefits. It merely established a remedy available pursuant to the plan.

The conflict between *Corporate Health* and *Moran* is plain. Two federal appellate courts interpret nearly identical enactments differently, rendering the law effective for all health care beneficiaries (including those subject to ERISA) in one state, but denying that remedy to any beneficiary of ERISA-sponsored plans in another state. This conflict presents an untenable situation, creating confusion among legislators and courts as they attempt to craft and apply alternatives for insureds denied health care coverage. Any efforts to reconcile the laws and to create workable alternatives, if necessary, are indefinitely stymied until this Court addresses the conflict.

On another level, the discordance between *Moran* and *Corporate Health* reflects an irreconcilable difference between two decisions of this Court that, by virtue of the conflict now existing between the Seventh and Fifth Circuits, compels action by this Court. As stated previously, the Fifth Circuit grounded its holding in *Pilot Life* and, to a lesser degree, *Ward*. The Seventh Circuit based its holding, in relevant part, on *Ward*.

In *Pilot Life*, this Court was asked to decide whether ERISA preempted a state common law action for bad faith breach of contract. Plaintiff alleged that the insurance company from which plaintiff's employer purchased group health insurance never intended to provide the benefits promised to plaintiff. Plaintiff's complaint sought damages for emotional distress and punitive damages. The *Pilot Life* court found that ERISA preempted plaintiff's claim. *Pilot Life*, 481 U.S. at 51, 54. The cause of action was not, as plaintiff asserted, exempt from ERISA preemption by virtue of the ERISA savings clause. *Id.* at

50-51. The bad faith breach of contract action was not a law derived from or solely applicable to insurance contracts. It owed its origins to general contract and tort law developed in Mississippi. For this reason, Plaintiff's claim failed the first consideration of the savings clause test, whether from a "common sense view" the law regulates insurance. *Id.*

The *Pilot Life* court further found that the breach of contract claim conflicted with Section 502(a) of ERISA, which prescribes the civil remedies available under ERISA. *Id.* at 54. Pursuant to Section 502(a), a plan participant or beneficiary may sue for enforcement of rights under a health benefit plan or for recovery of benefits improperly denied, but no more. The scope of the remedy's provision, moreover, was purposefully broad, so that it preempted the exercise of both conflicting and supplementary remedies not otherwise available pursuant to ERISA. *Id.*

Eleven years after *Pilot Life*, this Court decided *Ward*, 526 U.S. 358. There, the Court examined California's "notice prejudice rule", which states that an insurer cannot raise late notice of a claim as a bar to coverage for that claim, unless the insurer can demonstrate that it was harmed by virtue of the untimely notice. This law, the Court held, could be saved from ERISA preemption under ERISA's savings clause. *Id.* at 374. In contrast to the bad faith contract claim at issue in *Pilot Life*, the California law was developed solely for and applied only to insurance contracts. *Id.* at 371. It was not a controlling rule of law for non-insurance contracts. Further, by operation of California law, the notice prejudice rule was automatically incorporated into any California contract of insurance. *Id.* at 374.

The Court also held that the notice prejudice rule was not preempted by the remedial terms of Section 502(a) of ERISA. *Id.* at 376-77. The notice prejudice rule was automatically incorporated into the plaintiff's health plan, the insurance contract at issue in the case. By virtue of the incorporation, it became a term of the plan so that when,

as in *Ward*, a participant sued under Section 502(a) to enforce the terms of the plan, those plan terms included the notice prejudice rule. The Court stated: "Ward sued under Section 502(a)(1)(B) 'to recover benefits due . . . under the terms of this plan.' The notice-prejudice rule supplied the relevant rule of decision for this Section 502(a) suit. The case therefore does not raise the question whether Section 502(a) provides the sole launching ground for an ERISA enforcement action." *Id.*

Critically, the Court addressed in a footnote an issue raised by the United States as an *amicus curiae*. *Id.* at 377, n. 7. The United States noted that in *Pilot Life*, the bad faith law was found to conflict with Section 502 and therefore the remedies sought by the plaintiff were pre-empted by ERISA. By contrast, the United States argued, the notice prejudice rule in *Ward* was a law that regulated insurance and was subject to the savings clause. Because the savings clause indicated an intent by the drafters of ERISA not to preempt laws regulating insurance, the United States asserted then the mere fact that the law provides "a state-law cause of action or remedy" should not subject the law to ERISA preemption under Section 502(a). *Id.*

The *Ward* court held that it need not address the effect of Section 502(a) preemption on a state law that was otherwise "saved" under the savings clause from ERISA preemption. *Id.* The facts before it did not require the Court to reach that issue. Rather, the Court concluded, plaintiff sought relief under Section 502(a) for denial of benefits, a remedy clearly allowed under ERISA, and thus plaintiff was not seeking a remedy that could conflict with or supplant the explicit remedies approved by the drafters of ERISA. *Id.*

In the instant appeal, however, the conflict presaged by the United States in *Ward* has emerged in *Corporate Health* and *Moran* and necessitates this Court's intervention. In both cases, the courts concluded that the state

laws at issue regulated insurance and therefore were "saved" from preemption. The *Moran* court ruled that the law was not preempted under Section 502(a) because, as an insurance law or regulation, it was incorporated into the health plan and subject to enforcement under Section 502(a). *Moran*, 2000 U.S. App. Lexis at *10. *Corporate Health* failed to adopt the same reasoning from the *Ward* court, and in fact cited *Ward* as authority for holding the IRO provision preempted by Section 502(a). *Corporate Health*, 514 F. 3d at 538. Thus, one court, *Moran*, interprets ERISA to allow a law to supplement the remedial provision of Section 502(a) as long as the law otherwise satisfies the necessary elements of the savings clause test. *Corporate Health*, by contrast, does not read the savings clause as superior to the preemption of Section 502(a). The Fifth Circuit reads ERISA to preempt a law that offers remedies other than those enumerated in Section 502(a), even if that law is saved from preemption by operation of the savings clause.

CONCLUSION

The differences between Circuits as to the preemptive effect of ERISA on independent review laws will preclude further implementation of these laws until this Court intervenes and clarifies which Circuit has reached the correct result. By so doing, the Court can also resolve the conflict between its own decisions regarding the proper application of the preemption language in Sections 514 and 502 of ERISA. The issues elucidated above must be addressed so that health care consumers can test seemingly profit-driven, arbitrary denials of health care by insurers against the scrutiny of independent physicians. Meaningful reform of managed care practices affecting

millions of health care consumers rests on this Court's decision to grant or deny *certiorari*.

Respectfully submitted,

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IN THE

Supreme Court of the United States

JOSE MONTEMAYOR, COMMISSIONER OF THE TEXAS DEPARTMENT OF INSURANCE; JOHN CORNYN, ATTORNEY GENERAL OF TEXAS,

Petitioners,

v.

CORPORATE HEALTH INSURANCE, INC.; AETNA HEALTH PLANS OF TEXAS, INC.; AETNA HEALTH PLANS OF NORTH TEXAS, INC.; AETNA LIFE INSURANCE COMPANY,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court of Appeals for the Fifth Circuit

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QUESTIONS PRESENTED

1. Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*, preempts the independent review requirements established by Texas Senate Bill 386.

2. Whether the Federal Employees Health Benefit Act, 5 U.S.C. § 8901 *et seq.*, preempts the independent review requirements established by Texas Senate Bill 386.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

The caption contains the names of all of the parties to the proceeding. All respondents are indirect subsidiaries or affiliates of Aetna, Inc., a publicly traded company.

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JURISDICTION

The judgment of the court of appeals was entered on June 20, 2000. A petition for panel rehearing was denied on July 27, 2000. Pet. App. D1, D6. The petition for a writ of certiorari was filed on October 24, 2000. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Texas' Senate Bill 386, the Supremacy Clause of the United States Constitution and the pertinent provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* and the Federal Employees Health Benefit Act, 5 U.S.C. § 8901 *et seq.* are reproduced in the appendix to this brief.

STATEMENT

1. In 1997, Texas enacted Senate Bill 386 ("SB 386"). The law purports to subject managed care organizations ("MCOs") to a set of independent review requirements through which members may appeal adverse determinations of medical necessity made by an MCO. Specifically, SB 386 applies to any "preferred provider organization" ("PPO"), "health maintenance organization" ("HMO"), or "any other person or entity which provides * * * or administers * * * health benefits * * * pursuant to a policy, plan, or contract." TEX. INS.

CODE ANN. art. 21.58A §§ 2(17)(B) and (C), 2(21)(B), 6 and 6A (West 1999).[1] The Texas statute requires MCOs to fund an independent review by a state-approved organization ("independent review organization" or "IRO") whenever an MCO's utilization review agent denies a plan enrollee's appeal of an adverse coverage determination. TEX. INS. CODE ANN. arts. 20A.09, 20A.12A, & 21.58A (West 1999); Pet. App. E1-E2, E4, E6-E7. In addition, the state provisions mandate that MCOs must "comply" with the IRO's determination of the "medical necessity" or "appropriateness" of the particular health care coverage at issue. *Id.* at E5.[2]

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[1] SB 386 applies by its terms to insurers writing health insurance policies, to self-insured plans, employers with employees in Texas who are covered under a health benefit plan or health insurance policy, and administrators as defined by article 21.07-6 of Texas Insurance Code. TEX. INS. CODE ANN. art. 21.58A §§ 2(2), 2(17)(A) and (B), 2(21)(A), (B) and (C), 6, and 6A (West 1999). While Section 14(e) of Article 21.58A purports to exempt ERISA plans from the IRO provisions, Texas nevertheless sought to apply them both to ERISA plans and to entities that administer benefits on behalf of those plans. Appearing as amicus in support of Texas in the courts below, the Secretary of Labor called the meaning of Section 14(e) "uncertain" under state law, and therefore characterized federal review as "premature." *See* Brief of Secretary of Labor as *Amicus Curiae* 23-27 (5th Cir. Mar. 12, 1999).

[2] The validity of the law's other provisions—which purport to establish liability for MCOs that fail to meet an "ordinary care" standard ("the liability provisions") and to prohibit MCOs from including indemnification clauses in their contracts and from retaliating against doctors or health care providers for advocating health care coverage ("the anti-indemnification and anti-retaliation provisions")—is not at issue before this Court. Even so, the court of appeals did not hold, as Texas implies, that one might use SB 386 (or any

[Footnote continued on next page]

2. Respondents—several indirect wholly-owned subsidiaries of Aetna, Inc.—are MCOs that are subject to SB 386's independent review provisions. Respondent Aetna Life Insurance Company, for example, makes coverage determinations for employee benefit plans (both insured and self-funded) governed by ERISA. *See* Record at 20:72-75. The petitioners are Jose Montemayor, Commissioner of the Texas Department of Insurance, and John Cornyn, Attorney General of Texas (collectively "Texas").

After SB 386 was enacted, respondents (hereinafter "Aetna") filed suit against Texas in federal district court, seeking declaratory and injunctive relief. With respect to the issues pertinent here, Aetna asserted that the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, and the Federal Employees Health Benefit Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, preempt the Texas statute's independent review provisions.

On cross-motions for summary judgment, the district court ruled, in pertinent part, that ERISA preempts the IRO provisions of SB 386. First, the court held that ERISA's express preemption provision, ERISA § 514(a), 29 U.S.C. § 1144(a), preempts the independent review provisions because they would "improperly mandate the administration of employee benefits" and would interfere with "the goal of uniformity [in ERISA

[Footnote continued from previous page]
other state law theory) to sue an MCO for improper benefits determinations, based on medical necessity or otherwise. In order to conclude that the liability provisions are not necessarily preempted in all of their applications, the court of appeals construed those provisions as applying only to a "limited universe of events," namely vicarious liability claims arising from the professional malpractice of a treating physician. *See, e.g.*, Pet. A8-A9.

plan regulation] that Congress sought to implement" through Section 514(a). Pet. App. B66-B67 (citation omitted). The court next concluded that SB 386 is not a state law regulating insurance under ERISA's saving clause, ERISA § 514(b)(2)(a); 29 U.S.C. § 1144(b)(2)(A). The court reasoned that, "on its face, the Act is obviously not 'limited to entities within the insurance industry.' Even though the Act lists health insurance carriers as one group covered by its terms, it also specifies that it applies to health maintenance organizations and other managed care entities for a health care plan." Pet. App. B15 (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985)).[3]

With respect to Aetna's claim that SB 386 also creates an impermissible alternate enforcement mechanisms, the court concluded that courts should determine on a case-by-case basis "[w]hether a claim seeks review of an adverse benefit determination [which would require preemption] or to secure quality coverage [which would not]." *Id.* at B76-B77. The court reached a similar conclusion on Aetna's claim that FEHBA preempts SB 386. *Id.* at B80. Having determined, however, that SB 386's independent review provisions are preempted by ERISA's express preemption provision and not saved under the saving clause, the court severed the IRO provisions from the remainder of the bill. *Id.* at B67-B68.

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[3] Because the district court ruled on the preemption question before this Court decided *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999), the court relied on Fifth Circuit precedent that required that a state regulation must satisfy all three McCarran-Ferguson factors in order to be viewed as a regulation of insurance under ERISA's saving clause. After determining that SB 386 failed the third factor because it is not limited to entities within the insurance industry, the district court thus had no occasion to analyze the other factors.

3. The court of appeals affirmed in part and reversed in part, concluding in pertinent part that ERISA and FEHBA preempt the independent review provisions of SB 386. Pet. App. A1-A26.

The court first held that Texas' IRO provisions fall squarely within the scope of ERISA's express preemption provision: "The [independent review] provisions allow a patient who has been denied coverage to appeal to an outside organization. Such an attempt to impose a state administrative regime governing coverage determinations is squarely within the ambit of ERISA's preemptive reach." Pet. App. A13. The court then held that ERISA's saving clause does not save the IRO provisions from preemption. Pet. App. A13-A16. The court first noted that the independent review provisions meet two of three factors for identifying the business of insurance under the McCarran Ferguson Act, 15 U.S.C. § 1012: although those provisions "probably do not * * * reallocat[e] * * * risk," they are aimed at insurers and regulate the insured-insurer relationship. *Id.* at A13-A14. The court noted, however, that the McCarran-Ferguson factors are not the end of the analysis under ERISA's saving clause, because *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), held that the clause does not save state laws that conflict with Section 502(a) of ERISA, 29 U.S.C. § 1132(a). Pet. App. A15.

The court explained that the independent review procedures conflict with Section 502(a) because they bind ERISA plans to the decisions of IROs regarding whether benefits must be paid, and "create[] an alternative mechanism through which plan members may seek benefits due them under the terms of the plan—the identical relief offered under § 1132(a)(1)(B) of ERISA." Pet. App. at A15-A16. The court therefore held that Texas' independent review provisions "conflict with ERISA's exclusive remedy and cannot be saved by the savings clause." *Id.* at A16.

Finally, the court of appeals determined that FEHBA preempts the independent review provisions under general conflict principles because those provisions conflict with the administrative remedy concerning benefits disputes provided by the Office of Personnel Management under FEHBA. Pet. App. A17 (citing 5 U.S.C. § 8902(j); 5 C.F.R. § 890.105-890.107). Having found the independent review provisions preempted, the court then severed them from the remainder of the statute.

4. Texas sought rehearing of the panel's ruling that ERISA and FEHBA preempt SB 386's IRO provisions, contending that that ruling was contrary to *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000). The court denied rehearing, but it issued a supplemental opinion rejecting Texas' reliance on *Pegram*. The court explained that *Pegram* held that mixed eligibility and treatment decisions made by an HMO through its physicians are not fiduciary acts under ERISA, but that *Pegram* did not "entail that every conceivable state law survives preemption so long as it is based on a mixed question of eligibility and treatment." Pet. App. D2-D3.

The court also rejected Texas' characterization of its IRO program as a law that merely implements a minimal level of care, like the state law at issue in *Metropolitan Life Ins. Co.*, 471 U.S. at 731, 758, by imposing a mandatory insurance contract term. The court concluded instead that "the IRO provisions here are plainly a state regime for reviewing benefit decisions." Pet. App. D6.

ARGUMENT

Texas contends that certiorari is warranted to resolve two distinct questions. First, Texas contends that this Court should decide whether a state law that conflicts with the exclusive remedies set forth in ERISA § 502(a), 29 U.S.C. § 1132(a), can nonetheless avoid federal preemption if that law regulates "insurance"

within the meaning of ERISA's "saving clause," 29 U.S.C. § 1144(b)(2)(A). Second, Texas argues that this Court should consider whether state laws that provide for external review of an MCO's determination that a particular treatment is not "medically necessary" are preempted by ERISA or FEHBA. There is no conflict among the lower courts with respect to Texas' proposed first question, which in any event is not properly presented in this case. With respect to the second question framed by Texas, the Fifth Circuit's ERISA preemption analysis could be viewed as inconsistent with the approach employed by the Seventh Circuit in a recent case, but any conflict between those two decisions is not yet ripe for this Court's review. Accordingly, plenary review is not warranted.

I. THIS CASE DOES NOT PROPERLY PRESENT THE ISSUE WHETHER STATE STATUTES THAT CONFLICT WITH THE EXCLUSIVE REMEDIES SET FORTH IN SECTION 502 ARE SAVED FROM PREEMPTION BY ERISA'S "SAVING CLAUSE."

1. Texas first presents the question whether Section 502(a) of ERISA, 29 U.S.C. § 1132(a), is "an exclusive remedy provision that preempts state insurance law remedies" that purportedly fall within the insurance "saving clause" of Section 514 of the statute, 29 U.S.C. § 1144. In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), however, this Court unanimously concluded that the remedies set forth in Section 502(a) are indeed exclusive. As the Court explained:

> [T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of [policy choices.] The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free

> to obtain remedies under state law that Congress rejected in ERISA.

Pilot Life, 481 U.S. at 54. This Court found additional support for the exclusivity of Section 502(a)'s remedies in the legislative history of ERISA, which demonstrated that Congress modeled the preemptive force of Section 502(a) on Section 301 of the Labor-Management Relations Act of 1947 ("LMRA"). *See Pilot Life*, 481 U.S. at 55. As this Court noted, Congress well understood that Section 301 of the LMRA preempts state statutes "even when [they] purport[] to authorize a remedy unavailable under the federal provision." *Pilot Life*, 481 U.S. at 55. Indeed, "the entire comparison of ERISA's § 502(a) to § 301 of the LMRA[] would make little sense if the remedies available to ERISA participants and beneficiaries under § 502(a) could be supplemented or supplanted by varying state laws." *Pilot Life*, 481 U.S. at 56.

In light of this Court's analysis in *Pilot Life*, any state law that purports to "supplement[] or supplant[]" the exclusive remedies that Congress made available in Section 502(a) is invalid under conventional conflict preemption principles. *See, e.g.*, *Boggs v. Boggs*, 520 U.S. 833, 844 (1997) ("In the face of [a] direct clash between state law and the provisions and objectives of ERISA, the state law cannot stand"). Texas submits, however, that the Court's analysis in *Pilot Life* does not control when, as Texas contends is the case here, the state law falls within the scope of ERISA's saving clause, 29 U.S.C.§ 1144(b)(2)(A). *See* Pet. 12-17. That argument is at odds with the specific reasoning of *Pilot Life*, which examined the effect of Section 502(a) in order to inform the Court's "understanding of the saving clause," *Pilot Life*, 481 U.S. at 52, and found Section 502(a)'s exclusive remedy to be an important factor in

determining that the state law was *not* saved under ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). *See Pilot Life*, 481 U.S. at 57.[4] As the Eighth Circuit has observed, "*Pilot Life* could not have stated with any greater clarity that the remedies afforded under ERISA are exclusive, and no state law purporting to supply additional remedies will escape * * * preempti[on] * * * as laws 'which regulate insurance' under § 1144(b)(2)(A)." *In re Life Ins. Co. of N. Am.*, 857 F.2d 1190, 1194 (8th Cir. 1988).

2. Texas correctly notes that the Solicitor General, whose reasoning was adopted by this Court in *Pilot Life*, *see Pilot Life*, 481 U.S. at 52, retreated from his position in *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999), and now apparently believes that ERISA's saving clause may save from preemption even statutes that conflict with the exclusive remedies provided by Section 502 of ERISA. *See UNUM*, 526 U.S. at 376-77 n.7. At the outset, that contention overlooks key aspects of this Court's analysis in *Pilot Life*. *Pilot Life* did not merely hold that Section 502 remedies are exclusive, and thus preemptive of conflicting state laws under conventional conflict preemption principles. *Pilot Life* also held that the exclusivity of Section 502 remedies is so important to ERISA's design that it must inform judicial interpretation of the scope of the business of "insurance" that Congress intended to reserve for the States. That statutory term, the Court held, must be defined not only

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[4] Indeed, in *Pilot Life* this Court noted that its "understanding of the saving clause must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA § 502(a)," and it found that Section 502(a)'s exclusive remedial scheme was the "most important[]" factor indicating that the state law was not saved. *See Pilot Life*, 481 U.S. at 52, 57. Texas' arguments here would turn that analysis on its head.

on the basis of the McCarran-Ferguson guideposts, but also with reference to "the role of the saving clause in ERISA as a whole." *Pilot Life*, 481 U.S. at 52. Thus, Texas errs at the outset in presuming that Congress intended to save for the States the authority to regulate anything that might be viewed as "insurance" under a common sense application of two out of the three McCarran-Ferguson guideposts.

In any event, by accepting the Solicitor General's arguments, *Pilot Life* did not purport to give the Solicitor General a continuing proxy to change the rule of law that this Court unanimously adopted in that case—a rule that for nearly fifteen years has been part of the accepted understanding of ERISA shared by litigants and the lower courts. Indeed, far more than the Solicitor General's change of heart would be necessary to meet the high burden that must be "borne by the party advocating the abandonment of an established precedent," especially where, as here, "the Court is asked to overrule a point of statutory construction." *Patterson v. McLean Credit Union*, 491 U.S. 164, 172 (1989).

Moreover, contrary to Texas' assertions, there is no conflict among the courts of appeals on the question whether ERISA's saving clause preserves from preemption state statutes that conflict with ERISA's substantive provisions. Although Texas suggests that the Seventh Circuit's recent decision in *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000), adopted such a view, *see* Pet. 6-12, the Seventh Circuit did not remotely suggest that it was departing from *Pilot Life*'s unanimous teaching that Section 502 is an exclusive provision that preempts State laws that provide alternative or additional remedies to plan participants or beneficiaries. *Moran* concluded that an Illinois statute that provides for a form of external review could not properly be characterized as an alternative or supplemental enforcement mechanism precluded by Section 502(a), but rather was a permissible "mandated contract term" that became

part of ERISA plans—and thus is enforceable in an action under Section 502(a)—by operation of state law. Because the Seventh Circuit did not view the Illinois statute as an impermissible state mechanism for enforcing plan benefits, it found that the statute did not run afoul of Section 502's exclusive sweep. *Moran*, 230 F.3d at 970-72. That is far from holding that, were the statute properly characterized as an alternative or supplemental enforcement mechanism, it could nonetheless be saved from preemption by the saving clause.[5]

Texas is even wider of the mark in claiming that *Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144 (2d Cir. 1995), and *PAS v. Travelers Ins. Co.*, 7 F.3d 349 (3d Cir. 1993), show that "[t]he Second and Third Circuits do not view *Pilot Life* as an obstacle to saving state insurance law remedies from preemption or to enforcement of those remedies in a state proceeding." Pet. 15. In both *Williams Trust* and *PAS* the sole, narrow issue properly before the court of appeals was whether the state statutes at issue were so completely preempted by ERISA that the defendants were entitled to *remove* actions filed under those statutes to federal court. *Williams Trust*, 50 F.3d at 146; *PAS*, 7 F.3d at 351. As Texas doubtless is aware, this Court unanimously ruled—on the same day it decided *Pilot Life*—that any state cause of action that falls within the scope of the civil enforcement provisions of Section 502(a) is so inherently and completely preempted that such a cause of

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[5] *Moran* might be read as creating a conflict with the decision below only with respect to one half of the *second* question that Texas has framed—*i.e.*, whether ERISA (but not FEHBA) preempts state laws that provide external review of a managed care organization's decision not to cover a particular treatment on the ground that such treatment is not "medically necessary." As discussed more fully below, any such conflict is not ripe for review.

action may be removed to federal court. *See Metropolitan Life Ins. v. Taylor*, 481 U.S. 58, 66 (1987). The Court was careful to point out, however, that not all preemption defenses support removal jurisdiction, and the fact that a particular preemption claim does not support "complete preemption" removal means only that the preemption defense must be adjudicated by the state courts—it does *not* mean that the statute is *not* preempted. *See id.* at 63-64; *see also Rivet v. Regions Bank of Louisiana*, 522 U.S. 470, 475-77 (1998); *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 165 (3d Cir. 1999), *cert. denied*, 120 S. Ct. 2687 (2000). The limited removal rulings in *Williams Trust* and *PAS* could not properly establish otherwise.

In any event, it is difficult to see how either *Williams Ins. Trust* or *PAS* can be read to support Texas' claim that ERISA's saving clause trumps all preemption defenses under the statute. In *Williams Ins. Trust* the case had been removed on the basis of ERISA's general preemption provision, 29 U.S.C. § 1144(a)—the very provision where the saving clause appears—and thus conflict preemption was not even at issue in the case. *See Williams Trust*, 50 F.3d at 147. *PAS* concluded that ERISA did not completely preempt a state insurance law that prohibited discrimination in the provision of mental health benefits, reasoning that such a law did *not* conflict with the provisions of Section 502(a). *PAS*, 7 F.3d at 356. Neither case can plausibly be read for the proposition that state statutes that *do* conflict with Section 502(a) are immune from preemption if they satisfy Texas' proposed interpretation of the saving clause.

3. Even if this Court were otherwise inclined to entertain the argument that *Pilot Life* should be revisited as Texas desires, this case would not be the proper vehicle in which to do so for three reasons. First, as explained more fully below, while the court of appeals correctly concluded that the saving clause does not save Texas' external review requirements, that court was mistaken in

believing that a common sense assessment of the McCarran-Ferguson factors points to the conclusion that Texas' statute regulates insurance. For that reason, an essential predicate for the question posed by Texas is simply missing in this case.

Second, although Texas has always maintained that its external review statute is not preempted by ERISA, it did not argue below that a statute that conflicts with the exclusive remedies provided by Section 502(a) may be saved nonetheless if the statute meets Texas' interpretation of ERISA's saving clause. Texas' argument has been—and remains, *see* Pet. 11, 13—that there is no conflict *at all* between Texas' external review statute and Section 502(a). Indeed, Texas advanced its saving-clause argument below solely in an attempt to establish that the external review provisions are not independently preempted by ERISA § 514(a) as laws "relat[ing] to" employee benefit plans, 29 U.S.C. § 1144(a). Texas did not urge below the legal issue on which it now seeks review: that the saving clause—interpreted solely by reference to the McCarran-Ferguson factors—is the beginning and end of the analysis for all preemption defenses under ERISA.[6] Not surprisingly, the court of appeals did not consider any such claim. Thus, review of that question would not be appropriate in this case solely because the court of appeals did apply ordinary principles of conflict preemption. *See, e.g., United States v. Williams*, 504 U.S. 36, 41 (1992) ("Our traditional rule * * * precludes a grant of certiorari * * * when the question

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[6] Such an argument would have required Texas to request that the court of appeals revisit *en banc* its analysis in *Ramirez v. Intercontinental Hotels*, 890 F.2d 760, 763-64 (5th Cir. 1989). Neither Texas' briefs before the panel nor its subsequent petition for rehearing *en banc* contained any such entreaty.

presented was not pressed or passed upon below") (internal quotation marks omitted).

Finally, although SB 386 by its terms expressly links the external review and liability provisions—thus strongly suggesting the existence of a state-law cause of action for members dissatisfied with the external review process—the court of appeals construed the liability provisions as extending only to "a limited universe of events"—*i.e.*, events that constitute medical negligence by a treating physician, for which the MCO would be vicariously liable. Pet. App. A8. In light of that construction, Texas now asserts that its external review provisions should be viewed as "creat[ing] a procedural right that an ERISA beneficiary can assert in a § 502(a) enforcement action." Pet. 11; *see also id.* at 13 (external review provisions are "incorporated into ERISA plans and supply the relevant rule of decision in a § 502(a) suit"). Aetna disagrees that Texas' external review requirements are a mere procedural mechanism or that state law may require "incorporation" of that mechanism into the terms of ERISA plans. Nonetheless, as Texas characterizes its own statute, this case does not present the distinct legal question whether the saving clause should be read to save state laws that conflict with Section 502(a). *See UNUM*, 526 U.S. at 377 n.7 ("We need not address the Solicitor General's current argument, for Ward has sued under § 502(a)(1)(B) for benefits due, and seeks only application of saved state insurance law as a relevant rule of decision in his § 502(a) action").

II. TEXAS' STATUTE IS CLEARLY PREEMPTED BY ERISA BECAUSE IT CONFLICTS WITH SECTION 502 AND IS NOT SAVED FROM SECTION 514 PREEMPTION.

Texas' independent review requirements purport to establish a binding alternate enforcement mechanism for claimants to receive plan benefits. That not only is precisely the sort of state law remedy that Congress in-

tended to preempt with ERISA's comprehensive remedial scheme in Section 502(a), but also runs afoul of ERISA's express preemption provision, 29 U.S.C. § 1144.

1. ERISA's express preemption provision provides that ERISA "shall supersede any and all State laws insofar as they * * * relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C. § 1144(a). Thus, any state law that "relates to" an ERISA plan must give way to ERISA's preemptive reach. This Court has "long acknowledged that ERISA's pre-emption provision is 'clearly expansive.'" *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 324 (1997) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995)). As this Court reaffirmed in *Travelers*, "§ 514 indicates Congress's intent to establish the regulation of employee welfare benefit plans 'as exclusively a federal concern.'" *Travelers*, 514 U.S. at 656 (citation omitted); *see also Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981) ("[Section 514] demonstrates that Congress intended to * * * establish pension plan regulation as exclusively a federal concern."). To that end, Section 514(a) preempts any state law that has a "connection with" or "reference to" such a plan. *Dillingham*, 519 U.S. at 324 (citation omitted).

The court of appeals in this case and the Seventh Circuit in *Moran*—the only courts of appeals that have considered whether ERISA preempts the type of statute at issue here—both correctly concluded that external review statutes plainly "relate to" ERISA plans under Section 514(a). Pet. App. A12-A13; *Moran*, 230 F.3d at 968-69. After all, a determination that a particular treatment is not "medically necessary" does not prohibit a member from *receiving* such a treatment; it is simply a judgment that the plan under which the member is covered is not obligated to *pay* for it—it is, in other words, a

coverage determination. *See, e.g., Thompson v. Gencare Health Systems, Inc.*, 202 F.3d 1072, 1074 (8th Cir. 2000). By forcing ERISA plans to pay for treatments that, in the plan's view, are not *covered*, Texas' external review provisions would have the clearly impermissible effect of "mandat[ing] employee benefit structures or their administration" and of "binding plan administrators to a[] particular choice." *Travelers*, 514 U.S. at 658, 659; *see also Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983). Indeed, because external review laws fundamentally interfere with the allocation and payment of plan benefits to participants and beneficiaries in accordance with the terms of the applicable plan documents, those laws go to the very core of ERISA. *See* ERISA § 2(b), 29 U.S.C. § 1001(b) ("[It is] the policy of this Act to protect * * * the interests of * * * beneficiaries" in ERISA plans); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) (explaining that ERISA plans are "obligat[ed] . . . [to] determin[e] the eligibility of claimants").

In addition, Texas' independent review law, if permitted to survive ERISA preemption, would frustrate Congress's aim of "'avoid[ing] a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.'" *Travelers*, 514 U.S. at 657. As this Court explained in *Fort Halifax*:

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants * * * [and] making disbursements * * * The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be re-

> quired to * * *. process claims in a certain way in some States but not in others * * *.

Fort Halifax, 482 U.S. at 9. Here, as in *Shaw*, *Holliday*, and *Alessi*, validation of Texas' external review law would impose inconsistent state requirements on the administration of ERISA plans and thereby frustrate ERISA's clear purpose to "secur[e] national uniformity in the administration of employee benefit plans." *Boggs*, 520 U.S. at 842.

Petitioners nonetheless contend that *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000), stands for the proposition that the independent review provisions at issue here do not "relate to" an ERISA plan, because Pegram noted that coverage or "'eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment.'" Pet. 24, quoting *Pegram*, 120 S. Ct. at 2157. *Pegram* held that ERISA does not impose a fiduciary duty on HMO physicians for their mixed eligibility and treatment decisions, *Pegram*, 120 S. Ct. at 2158. Because *Pegram* was not a preemption case, this Court "ha[d] no occasion to discuss" the standards governing a § 502(a) claim for benefits nor "the interaction of such a claim with state law causes of action," *Pegram*, 120 S. Ct. at 2154 n.9; *see also id.* at 2158. Indeed, to the extent that *Pegram* even so much as hinted at any principle of preemption law, it at most suggested that a *physician* who makes coverage decisions in the course of treating his patients is not thereby shielded from the state's malpractice laws. That principle is unexceptionable but, as the court of appeals correctly noted in denying Texas' petition for rehearing, it is not particularly helpful to Texas here. Pet. App. D2-D3, n.7 (noting that even assuming that malpractice causes of

action are not preempted, SB 386's external review procedures "would still be preempted.").[7]

2. The court of appeals correctly concluded that ERISA's saving clause does not save the external review provisions of SB 386 from preemption. Pet. App. A15. The conflict between the external review provisions and Section 502(a) alone establishes that those provisions are not part of the business of "insurance" that Congress intended to save from preemption. *Pilot Life*, 481 U.S. at 52. But even if the inquiry were restricted to the McCarran-Ferguson factors and "a common-sense view of the matter" (*UNUM*, 526 U.S. at 367), the external review provisions do not regulate insurance within the meaning of the saving clause.[8]

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[7] Moreover, *Pegram* addressed mixed eligibility and treatment decisions in the context of a "staff model" managed care plan, in which physicians are employees of the plan and make coverage decisions on behalf of the plan. Aetna does not operate any "staff model" plans in Texas; as the court of appeals noted, Aetna contracts with *independent* providers and hospitals. Pet. App. A3. Indeed, under Texas law "staff model" plans would likely run afoul of the State's prohibition on the corporate practice of medicine. *See Garcia v. Texas State Bd. of Med. Examiners*, 384 F. Supp. 434, 437 (W.D. Tex. 1974) (*per curiam*), *aff'd*, 421 U.S. 995 (1975). Thus, it is hard to see how *Pegram*'s discussion of physicians who make both medical and coverage judgments could have any application to Aetna, which deals solely with coverage issues.

[8] The McCarran-Ferguson factors are "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *UNUM*, 526 U.S. at 367; *see also Metropolitan Life*, 471 U.S. at 743. Although a law

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Texas' external review provisions do not "regulate insurance" under a common sense understanding, because Texas' law is not directed specifically at the managed care industry *as insurers* or even at the insurance industry in general. *See UNUM*, 526 U.S. 375; *Pilot Life*, 481 U.S. at 50. Rather, the IRO procedures provide a dispute resolution mechanism of certain coverage determinations (those involving "medical necessity"), a matter not unique to the insurance industry. To cite only the most obvious example, Texas' law expressly targets not merely entities that assume risk for health care services, but also "*any* other person or entity which * * * *administers* * * * health benefits * * * pursuant to a policy, plan, or contract." TEX. INS. CODE ANN. art. 21.58A §§ 2(17)(B) and (C), 2(21)(B), 6 and 6A.

Senate Bill 386 thus quite clearly reaches not only plans in which Aetna assumes some financial risks of coverage, but also plans—particularly self-funded employee benefit plans—that Aetna merely administers in exchange for a fee. Texas' law expressly reaches, in other words, the prime example of what Congress intended for States *not* to reach under the guise of "insurance." *See FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (discussing ERISA's "deemer clause," 29 U.S.C. § 1144(b)(2)(B), which precludes states from using the saving clause to "deem" employee benefit plans "insurers" or to "deem" such plans "to be engaged in the business of insurance"). For that same reason, SB 386's external review procedures do not satisfy the third McCarran-Ferguson factor. Indeed, while the court of appeals dismissed the third McCarran-Ferguson factor on the

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need not meet all of three McCarran-Ferguson factors to fall within the protection of the saving clause, *see UNUM*, 526 U.S. at 373, the Court has continued to scrutinize all three factors.

theory that Texas may permissibly reach any "entities *acting* as insurers," Pet. App. A14 (emphasis in original), that is simply another way of saying that Texas could permissibly "deem" self-funded plans to be "insurers" for regulatory purposes, a boundless theory that would essentially nullify ERISA's "deemer clause." *See FMC Corp.*, 498 U.S. at 63-64.

Moreover, as the court of appeals essentially conceded, Texas' external review requirements do not meet the first McCarran-Ferguson factor because they do not operate to transfer or spread a policyholder's risk. *See* Pet. App. A15 ("the provisions probably do not meet the first factor"). Regardless of the particular remedy available to obtain benefits under the terms of a plan—whether under Section 502(a) or through a state mandated appeals process of independent review—the basic contract terms providing benefits to a policyholder for "medically necessary" health care remain controlling. *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 130-31 (1982). The relevant risk is fixed when the contract is completed (*id.* at 131), and—notwithstanding Texas' law—a member's health plan continues to bear the risk of covering only "medically necessary" health care, while members continue to bear the financial risk of covering any desired health care that is not medically necessary.

Finally, given Texas' current insistence that its external review provisions merely mandate a "procedural right" (Pet. 11), those provisions can scarcely be considered "integral" to any insurance relationship. Like the state common law bad faith claim at issue in *Pilot Life*, Texas' IRO process "does not define the terms of the relationship between the insurer and the insured; it declares only that, whatever terms have been agreed upon in the insurance contract, [such as, in this case, coverage for "medically necessary" health care,] a breach of that contract may * * * allow a policyholder to

obtain" certain state law remedies. *Pilot Life*, 481 U.S. at 51.

In sum, because Texas' IRO provisions fail to "regulate insurance" from a common-sense view of the matter and clearly fail to satisfy any of the McCarran-Ferguson factors, those provisions cannot be viewed as "regulating insurance" within the meaning of Section 514(b)(2)(A). Accordingly, those provisions are independently preempted not only under Section 502(a), but also under Section 514(a).

3. In *Moran*, the Seventh Circuit recently held that ERISA does not preempt an Illinois statute's provisions requiring independent review of certain medical necessity decisions. *Moran*, 230 F.3d at 972-73. After concluding that the Illinois law falls "squarely" within ERISA's express preemption clause because it would affect benefit determination procedures (*id.* at 968), the court concluded that Section 514 does not invalidate Illinois' law because that law regulates insurance within the meaning of the saving clause, *id.* at 969-70. With respect to "conflict" preemption, the court determined that the Illinois statute's independent review provisions do *not* "creat[e] an alternative remedy scheme that conflicts with [§] 502(a)," but rather are incorporated into the terms of the insurance contract by operation of state law. *Id.* at 970. Thus, the court held, any suit to enforce the Illinois review procedures would be "simply a suit to enforce the terms of the plan—precisely the sort of suit that is contemplated by [§] 502(a)(1)(B)." *Id.*[9]

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[9] *Moran*'s state law analysis appears to be based upon an overly broad proposition of law that does not necessarily apply in this case. That proposition is that "Illinois laws automatically are incorporated into all contracts of insurance in that state." *Moran*, 230 F.3d at 966; *see also id.* at 969. In Texas, however, not every law is incorporated into every

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As Judge Posner recognized in dissenting from the Seventh Circuit's denial of rehearing *en banc*, the *Moran* panel's logic would permit the "transparent * * * evasion of ERISA's preemption clause," a result that is plainly impermissible. *Moran*, 230 F.3d at 972-73 (Posner, J., dissenting from denial of rehearing *en banc*). States could evade ERISA through the simple artifice of declaring that a state law that ERISA would otherwise preempt is "incorporated" into the terms of a plan. That anomalous analysis may merit this Court's review in an appropriate case, but review at this time would be premature. Only two courts of appeals have even considered whether ERISA preempts state laws that require external review, even though, according to Texas and its amici, "[m]any states" have adopted "some form of independent, external review process." Pet. 27 & n.24; *see also* Brief of the States of Massachusetts *et al.* as Amici Curiae in Support of Petitioners at 2 &. n.4.[10]

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contract of insurance. *See Jun v. Lloyds*, No. 03-00-00110-CV, 2000 WL 1675683, at *3-4 (Tex. App.-Austin, Nov. 9, 2000, no pet. hist.).

[10] Contrary to Texas' petition for certiorari, there is no conflict among other courts of appeals about whether ERISA preempts state independent review laws. *See* Pet. 13-15. The decisions from Second, Third, Sixth and Eighth Circuits on which Texas relies involved state insurance laws which, unlike the state independent review law at issue here, do not purport to establish additional *remedies* in conflict with § 502(a), but merely mandate minimum insurance *benefits*, like the insurance law held not preempted in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). *See Williams Ins. Trust*, 50 F.3d at 151 (state insurance law requiring that interest on life insurance benefits be computed from the date of death); *PAS*, 7 F.3d at 356-57 (state insurance law prohibiting discrimination in the provision of men-

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The widespread adoption of such laws should afford this Court ample opportunity to address the issues raised by Texas after several other courts of appeals have had an adequate opportunity to address the interrelation between external review laws and ERISA. Indeed, if Texas is correct that *Pegram* has some relevance to the preemption analysis that applies in this context—though neither the Fifth Circuit nor the Seventh Circuit believed that *Pegram* addressed the issues presented here—the very recency of that decision would itself counsel against review of Texas' arguments at this time, before the lower courts have had an adequate opportunity to assimilate that ruling.

As this Court has recognized, the percolation of important legal questions throughout the judicial system prior to a grant of a writ of certiorari offers this Court the benefits of enhanced development and consideration of the issues and of the various factual settings in which they arise. *See, e.g.*, *United States v. Mendoza*, 464 U.S. 154, 160 (1984); *E.I. du Pont de Nemours & Co. v. Train*, 430 U.S. 112, 135 n.26 (1977) (noting the "wisdom of allowing difficult issues to mature through full consideration by the courts of appeals"). That percolation could obviate any need for review altogether—by solidifying lower court support for the correct rule and

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tal health benefits); *Ruble v. UNUM Life Insurance Co. of Am.*, 913 F.2d 295, 297 (6th Cir. 1990) (state insurance law prohibiting insurance benefits from being reduced by any amount of social security benefits received); *Donatelli v. Home Insurance Co.*, 992 F.2d 763, 764-65 (8th Cir. 1993) (state insurance law requiring insurers to provide accidental death benefits in the event of death by suicide while insane). Unlike the state IRO procedures at issue here, those cases did not approve an alternate remedial scheme that directly conflicts with ERISA's civil enforcement provisions.

causing the Seventh Circuit to reconsider *Moran's* rule *en banc*.

Permitting further percolation of the preemption issue in the lower courts is particularly appropriate because the apparent disagreement between the Seventh and Fifth circuits may be rendered moot by federal legislative or regulatory developments. Leaders of both political parties are currently advocating separate versions of a Patients' Bill of Rights. *See, e.g.*, H.R. 2990, 106th Cong. (1999); H.R. 2723, 106th Cong. (1999); S. 1344, 106th Cong. (1999); S.Amend. 3694, 106th Cong. (2000); BNA's Health Care Daily Report, *Plan Regulation: Bill of Rights Could Make Comeback in Next Session; Business Groups Prepare*, Bureau of National Affairs, Inc. (Dec. 6, 2000). The Senate and House versions of that bill contain provisions for external independent review at Sections 121 and 1103, respectively. *See, e.g.*, H.R. 2990, 106th Cong. (1999). That legislation might well achieve many of the objectives of measures such as SB 386, without disrupting the nationally uniform regulation of employee benefit plans that Congress intended in ERISA. *Travelers*, 514 U.S. at 656.

In addition, less than three weeks ago the U.S. Department of Labor published a new ERISA regulation that revises the benefit claims procedures for ERISA plans. 65 Fed. Reg. 70246 (2000) (to be codified at 29 C.F.R. Part 2560). In particular, the regulation establishes new standards for the conduct of reviews of adverse benefit determinations with respect to group health plans and plans providing disability benefits. The regulation requires *de novo* review of such determinations by a third party fiduciary who is neither the individual who made the initial determination nor that person's subordinate. *Id.* at 70268-69 (to be codified at 29 C.F.R. Part 2560.503–1(h)). In addition, the review must take into account all comments, documents, records, and other information submitted by the claimant, without regard to whether such information was previously submitted or

relied upon in the initial determination. *Id.* at 70269. With regard to reviews of determinations based on a medical judgment, including medical necessity and appropriateness decisions, the regulation requires consultation with an appropriately qualified health care professional who is different from, and not subordinate to, any individual who was consulted in connection with the initial decision. *Id.* The effect of that new regulation on the issue of ERISA's preemption of state external review laws has yet to be evaluated by any lower federal court. In these circumstances, review by this Court of the decision below would be premature and unwarranted.

III. TEXAS HAS FAILED TO IDENTIFY ANY REASON WARRANTING REVIEW OF THE FIFTH CIRCUIT'S FEHBA RULING.

The court of appeals determined that FEHBA preempts SB 386's independent review procedures because those procedures squarely conflict with the administrative benefit review procedures established by the Office of Personnel Management under FEHBA. Pet. App. A17 (citing 5 U.S.C. § 8902(j); 5 C.F.R. § 890.105-890.107). Although Texas' second question ostensibly seeks review of that determination (see Pet. i), Texas presents no argument impugning the correctness of the court of appeals' FEHBA analysis and identifies no lower court conflict of any sort on that issue. Indeed, although the bulk of Texas' arguments under ERISA derive from Texas' assertion that SB 386 is a permissible regulation of insurance, FEHBA expressly preempts state laws relating to "insurance." See 5 U.S.C. § 8902(m)(1). Because Texas proffers no reason for this Court to review any FEHBA issue, this Court should consider Texas' FEHBA claim abandoned.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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December 8, 2000

APPENDIX

CONSTITUTIONAL AND STATUTORY APPENDIX

CONSTITUTION OF THE UNITED STATES OF AMERICA
ARTICLE VI, CLAUSE 2

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

TEXAS SENATE BILL 386
AN ACT

relating to review of and liability for certain health care treatment decisions.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Title 4, Civil Practice and Remedies Code, is amended by adding Chapter 88 to read as follows:

CHAPTER 88. HEALTH CARE LIABILITY

Sec. 88.001. DEFINITIONS. In this chapter:

(1) "Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community.

(2) "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents.

(3) "Health care plan" means any plan whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services.

(4) "Health care provider" means a person or entity as defined in Section 1.03(a)(3), Medical Liability and Insurance Improvement Act of Texas (Article 4590i, Vernon's Texas Civil Statutes).

(5) "Health care treatment decision" means a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.

(6) "Health insurance carrier" means an authorized insurance company that issues policies of accident and sickness insurance under Section 1, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70–1, Vernon's Texas Insurance Code).

(7) "Health maintenance organization" means an organization licensed under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

(8) "Managed care entity'' means any entity which delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer or a pharmacy licensed by the State Board of Pharmacy.

(9) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) or a nonprofit health corporation certified under Section 5.01, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes); or

(C) another person wholly owned by physicians.

(10) "Ordinary care" means, in the case of a health insurance carrier, health maintenance organization, or managed care entity, that degree of care that a health insurance carrier, health maintenance organization, or managed care entity of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization, or managed care entity, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances.

Sec. 88.002. APPLICATION. **(a)** A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

(b) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its:

(1) employees;

(2) agents;

(3) ostensible agents; or

(4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.

(c) It shall be a defense to any action asserted against a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan that:

(1) neither the health insurance carrier, health maintenance organization, or other managed care entity, nor any employee, agent, ostensible agent, or representative for whose conduct such health insurance carrier, health maintenance organization, or other managed care entity is liable under Subsection (b), controlled, influenced, or participated in the health care treatment decision; and

(2) the health insurance carrier, health maintenance organization, or other managed care entity did not deny or delay payment for any treatment prescribed or recommended by a provider to the insured or enrollee.

(d) The standards in Subsections (a) and (b) create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity.

(e) This chapter does not create any liability on the part of an employer, an employer group purchasing organization, or a pharmacy licensed by the State Board of Pharmacy that purchases coverage or assumes risk on behalf of its employees.

(f) A health insurance carrier, health maintenance organization, or managed care entity may not remove a physician or health care provider from its plan or refuse

to renew the physician or health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

(g) A health insurance carrier, health maintenance organization, or other managed care entity may not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company which includes an indemnification or hold harmless clause for the acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity. Any such indemnification or hold harmless clause in an existing contract is hereby declared void.

(h) Nothing in any law of this state prohibiting a health insurance carrier, health maintenance organization, or other managed care entity from practicing medicine or being licensed to practice medicine may be asserted as a defense by such health insurance carrier, health maintenance organization, or other managed care entity in an action brought against it pursuant to this section or any other law.

(i) In an action against a health insurance carrier, health maintenance organization, or managed care entity, a finding that a physician or other health care provider is an employee, agent, ostensible agent, or representative of such health insurance carrier, health maintenance organization, or managed care entity shall not be based solely on proof that such person's name appears in a listing of approved physicians or health care providers made available to insureds or enrollees under a health care plan.

(j) This chapter does not apply to workers' compensation insurance coverage as defined in Section 401.011, Labor Code.

(k) An enrollee who files an action under this chapter shall comply with the requirements of Section 13.01, Medical Liability and Insurance Improvement Act of

Texas (Article 4590i, Vernon's Texas Civil Statutes), as it relates to cost bonds, deposits, and expert reports.

Sec. 88.003. LIMITATIONS ON CAUSE OF ACTION. **(a)** A person may not maintain a cause of action under this chapter against a health insurance carrier, health maintenance organization, or other managed care entity that is required to comply with the utilization review requirements of Article 21.58A, Insurance Code, or the Texas Health Maintenance Organization Act (Chapter 20A Vernon's Texas Insurance Code), unless the affected insured or enrollee or the insured's or enrollee's representative:

(1) has exhausted the appeals and review applicable under the utilization review requirements; or

(2) before instituting the action:

(A) gives written notice of the claim as provided by Subsection (b); and

(B) agrees to submit the claim to a review by an independent review organization under Article 21.58A, Insurance Code, as required by Subsection (c).

(b) The notice required by Subsection (a)(2)(A) must be delivered or mailed to the health insurance carrier, health maintenance organization, or managed care entity against whom the action is made not later than the 30th day before the date the claim is filed.

(c) The insured or enrollee or the insured's or enrollee's representative must submit the claim to a review by an independent review organization if the health insurance carrier, health maintenance organization, or managed care entity against whom the claim is made requests the review not later than the 14th day after the date notice under Subsection (a)(2)(A) is received by the health insurance carrier, health maintenance organization, or managed care entity. If the health insurance carrier, health maintenance organization, or managed care

entity does not request the review within the period specified by this subsection, the insured or enrollee or the insured's or enrollee's representative is not required to submit the claim to independent review before maintaining the action.

(d) Subject to Subsection (e), if the enrollee has not complied with Subsection (a), an action under this section shall not be dismissed by the court, but the court may, in its discretion, order the parties to submit to an independent review or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed 30 days for such purposes. Such orders of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with Subsection (a).

(e) The enrollee is not required to comply with Subsection (c) and no abatement or other order pursuant to Subsection (d) for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

> **(1)** harm to the enrollee has already occurred because of the conduct of the health insurance carrier, health maintenance organization, or managed care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of such carrier, organization, or entity for whose conduct it is liable under Section 88.002(b); and
>
> **(2)** the review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier, organization, or entity finds after hearing that such pleading was not made in good faith, in which case the court may enter an order pursuant to Subsection (d).

(f) If the insured or enrollee or the insured's or enrollee's representative seeks to exhaust the appeals and review or provides notice, as required by Subsection (a), before the statute of limitations applicable to a claim

against a managed care entity has expired, the limitations period is tolled until the later of:

(1) the 30th day after the date the insured or enrollee or the insured's or enrollee's representative has exhausted the process for appeals and review applicable under the utilization review requirements; or

(2) the 40th day after the date the insured or enrollee or the insured's or enrollee's representative gives notice under Subsection (a)(2)(A).

(g) This section does not prohibit an insured or enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the insured's or enrollee's health in serious jeopardy.

SECTION 2. Section 6, Article 21.58A, Insurance Code, is amended by amending Subsection (b) and adding Subsection (c) to read as follows:

(b) The procedures for appeals must be reasonable and shall include the following:

(1) a provision that an enrollee, a person acting on behalf of the enrollee, or the enrollee's physician or health care provider may appeal the adverse determination and shall be provided, on request, a clear and concise statement of the clinical basis for the adverse determination;

(2) a list of documents needed to be submitted by the appealing party to the utilization review agent for the appeal;

(3) a provision that appeal decisions shall be made by a physician, provided that, if the appeal is denied and within 10 working days the health care provider sets forth in writing good cause for having a particular type of a specialty provider review the

case, the denial shall be reviewed by a health care provider in the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the adverse determination;

(4) in addition to the written appeal, a method for an expedited appeal procedure for emergency care denials and denials of continued stays for hospitalized patients, which shall include a health care provider who has not previously reviewed the case; such appeal must be completed no later than one working day following the day on which the appeal, including all information necessary to complete the appeal, is made to the utilization review agent; and

(5) written notification to the appealing party of the determination of the appeal, as soon as practical, but in no case later than the 30th day after the date the utilization agent receives [~~30 days after receiving all the required documentation of~~] the appeal. If the appeal is denied, the written notification shall include a clear and concise statement of:

(A) the clinical basis for the appeal's denial;

(B) [~~and~~] the specialty of the physician making the denial; and

(C) notice of the appealing party's right to seek review of the denial by an independent review organization under Section 6A of this article and the procedures for obtaining that review.

(c) Notwithstanding any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an independent review organization as provided by Section 6A of this article and is not required to comply with procedures for an internal review of the utilization review agent's adverse determination. For purposes of this sec-

tion, "life-threatening condition" means a disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted.

SECTION 3. Article 21.58A, Insurance Code, is amended by adding Section 6A to read as follows:

Sec. 6A. INDEPENDENT REVIEW OF ADVERSE DETERMINATIONS. A utilization review agent shall:

(1) permit any party whose appeal of an adverse determination is denied by the utilization review agent to seek review of that determination by an independent review organization assigned to the appeal in accordance with Article 21.58C of this code;

(2) provide to the appropriate independent review organization not later than the third business day after the date that the utilization review agent receives a request for review a copy of:

(A) any medical records of the enrollee that are relevant to the review;

(B) any documents used by the plan in making the determination to be reviewed by the organization;

(C) the written notification described by Section 6(b)(5) of this article;

(D) any documentation and written information submitted to the utilization review agent in support of the appeal; and

(E) a list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal;

(3) comply with the independent review organization's determination with respect to the medical necessity or appropriateness of health care items and services for an enrollee; and

(4) pay for the independent review.

SECTION 4. Section 8, Article 21.58A, Insurance Code, is amended by adding Subsection (f) to read as follows:

(f) Confidential information in the custody of a utilization review agent may be provided to an independent review organization, subject to rules and standards adopted by the commissioner under Article 21.58C of this code.

SECTION 5. Subdivision (3), Subsection (a), Section 9, Texas Health Maintenance Organization Act (Article 20A.09, Vernon's Texas Insurance Code), is amended to read as follows:

(3) An evidence of coverage shall contain:

(A) no provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in Section 14 of this Act; and

(B) a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:

(i) the medical, health care services, or single health care service and the issuance of other benefits, if any, to which the enrollee is entitled under the health care plan or single health care service plan;

(ii) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, in-

cluding any deductible or co-payment feature;

(iii) where and in what manner information is available as to how services may be obtained; and

(iv) a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints, including the enrollee's right to appeal denials of an adverse determination, as that term is defined by Section 12A of this Act, to an independent review organization and the procedures for making an appeal to an independent review organization. Any subsequent changes may be evidenced in a separate document issued to the enrollee.

SECTION 6. Section 12, Texas Health Maintenance Organization Act (Article 20A.12, Vernon's Texas Insurance Code), is amended to read as follows:

Sec. 12. COMPLAINT SYSTEM. (a) Every health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of oral and written complaints initiated by enrollees concerning health care services.

(b) The commissioner may examine the complaint system.

SECTION 7. The Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code) is amended by adding Section 12A to read as follows:

Sec. 12A. REVIEW OF ADVERSE DETERMINATIONS. (a) The complaint system required by Section 12 of this Act must include:

(1) notification to the enrollee of the enrollee's right to appeal an adverse determination to an independent review organization;

(2) notification to the enrollee of the procedures for appealing an adverse determination to an independent review organization; and

(3) notification to an enrollee who has a life-threatening condition of the enrollee's right to immediate review by an independent review organization and the procedures to obtain that review.

(b) The provisions of Article 21.58A, Insurance Code, that relate to independent review apply to a health maintenance organization under this section as if the health maintenance organization were a utilization review agent.

(c) In this section:

(1) "Adverse determination" means determination by a health maintenance organization that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary.

(2) "Independent review organization" means an organization selected as provided under Article 21.58C, Insurance Code.

(3) "Life-threatening condition" has the meaning assigned by Section 6, Article 21.58A, Insurance Code.

SECTION 8. Subchapter E, Chapter 21, Insurance Code, is amended by adding Article 21.58C to read as follows:

Art. 21.58C. STANDARDS FOR INDEPENDENT REVIEW ORGANIZATIONS

Sec. 1. Definitions. In this article:

(1) "Life-threatening condition" has the meaning assigned by Section 6, Article 21.58A of this code.

(2) "Payor" has the meaning assigned by Section 2, Article 21.58A of this code.

Sec. 2. CERTIFICATION AND DESIGNATION OF INDEPENDENT REVIEW ORGANIZATIONS. (a) The commissioner shall:

(1) promulgate standards and rules for:

(A) the certification, selection, and operation of independent review organizations to perform independent review described by Section 6, Article 21.58A of this code; and

(B) the suspension and revocation of the certification;

(2) designate annually each organization that meets the standards as an independent review organization;

(3) charge payors fees in accordance with this article as necessary to fund the operations of independent review organizations; and

(4) provide ongoing oversight of the independent review organizations to ensure continued compliance with this article and the standards and rules adopted under this article.

(b) The standards required by Subsection (a)(1) of this section must ensure:

(1) the timely response of an independent review organization selected under this article;

(2) the confidentiality of medical records transmitted to an independent review organization for use in independent reviews;

(3) the qualifications and independence of each health care provider or physician making review determinations for an independent review organization;

(4) the fairness of the procedures used by an independent review organization in making the determinations; and

(5) timely notice to enrollees of the results of the independent review, including the clinical basis for the determination.

(c) The standards adopted under Subsection (a)(1) of this section must include standards that require each independent review organization to make its determination:

(1) not later than the earlier of:

(A) the 15th day after the date the independent review organization receives the information necessary to make the determination; or

(B) the 20th day after the date the independent review organization receives the request that the determination be made; and

(2) in the case of a life-threatening condition, not later than the earlier of:

(A) the fifth day after the date the independent review organization receives the information necessary to make the determination; or

(B) the eighth day after the date the independent review organization receives the request that the determination be made.

(d) To be certified as an independent review organization under this article, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

(1) for an applicant that is publicly held, the name of each stockholder or owner of more than five percent of any stock or options;

(2) the name of any holder of bonds or notes of the applicant that exceed $100,000;

(3) the name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the affiliation or control;

(4) the name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed under Subdivision (3) of this subsection and a description of any relationship the named individual has with:

(A) a health benefit plan;

(B) a health maintenance organization;

(C) an insurer;

(D) a utilization review agent;

(E) a nonprofit health corporation;

(F) a payor;

(G) a health care provider; or

(H) a group representing any of the entities described by Paragraphs (A) through (G) of this subdivision;

(5) the percentage of the applicant's revenues that are anticipated to be derived from reviews conducted under Section 6A, Article 21.58A of this code;

(6) a description of the areas of expertise of the health care professionals making review determinations for the applicant; and

(7) the procedures to be used by the independent review organization in making review determi-

nations with respect to reviews conducted under Section 6A, Article 21.58A of this code.

(e) The independent review organization shall annually submit the information required by Subsection (d) of this section. If at any time there is a material change in the information included in the application under Subsection (d) of this section, the independent review organization shall submit updated information to the commissioner.

(f) An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a payor or a trade or professional association of payors.

(g) An independent review organization conducting a review under Section 6A, Article 21.58A of this code is not liable for damages arising from the determination made by the organization. This subsection does not apply to an act or omission of the independent review organization that is made in bad faith or that involves gross negligence.

SECTION 9. Chapter 88, Civil Practice and Remedies Code, as added by this Act, applies only to a cause of action that accrues on or after the effective date of this Act. An action that accrues before the effective date of this Act is governed by the law applicable to the action immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 10. (a) The change in law made by Sections 2 through 4 and 6 through 8 of this Act applies only to an adverse determination of a utilization review agent or health maintenance organization made on or after the effective date of this Act.

(b) The change in law made by Section 5 of this Act to Section 9, Texas Health Maintenance Organization Act (Article 20A.09, Vernon's Texas Insurance Code), applies only to an evidence of coverage that is delivered, issued for delivery, or renewed on or after

January 1, 1998. An evidence of coverage that is delivered, issued for delivery, or renewed before January 1, 1998, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 11. This Act takes effect September 1, 1997.

SECTION 12. The importance of this legislation and the crowded condition of the calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each house be suspended, and this rule is hereby suspended.

TITLE 29—LABOR

CHAPTER 18—EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS
SUBTITLE A—GENERAL PROVISIONS

* * * * *

Part 5—Administration and Enforcement

* * * * *

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action
A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under

the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) or under subsection (i) or (*l*) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title;

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a par-

ticipant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title [subtitle] or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

* * * * *

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

* * * * *

(b) Construction and application

* * * * *

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insur-

ance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * * * *

TITLE 5—GOVERNMENT ORGANIZATION AND EMPLOYEES
PART III. EMPLOYEES
SUBPART G. INSURANCE AND ANNUITIES
CHAPTER 89. HEALTH INSURANCE

§ 8902. Contracting Authority

* * * * *

(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

(8)

Supreme Court, U.S.
FILED
DEC 15 2000
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No. 00-665

In the Supreme Court of the United States

JOSE MONTEMAYOR, COMMISSIONER OF THE TEXAS DEPARTMENT OF INSURANCE; JOHN CORNYN, ATTORNEY GENERAL OF TEXAS,
Petitioners,

v.

CORPORATE HEALTH INSURANCE, INC.; AETNA HEALTH PLANS OF TEXAS, INC.; AETNA HEALTH PLANS OF NORTH TEXAS, INC.; AETNA LIFE INSURANCE COMPANY,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITIONERS' REPLY TO RESPONDENTS' BRIEF IN OPPOSITION

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UNITED STATES GENERAL ACCOUNTING OFFICE, REPORT NO. GAO/HEHS-98-154, EMPLOYER-BASED MANAGED CARE PLANS: ERISA'S EFFECT ON REMEDIES FOR BENEFIT DENIALS AND MEDICAL MALPRACTICE (July 1998) 6

I. The Question Presented Is Ripe for Adjudication.

The question presented is precisely the question left unanswered by the Court in *UNUM Life Insurance Co. of America v. Ward*: whether a state insurance law that falls within the savings clause is nevertheless preempted by ERISA §502(a) if it provides an independent state-law remedy. 526 U.S. 358, 376 (1999). The question arose in this case when the Fifth Circuit extended *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987), to hold that Texas' Independent Review Process ("IRO process")—a state insurance law within the meaning of the savings clause—nevertheless was preempted because it conflicts with ERISA §502(a). Appendix to Petition for Writ of Certiorari (hereafter Pet. App.) at A-15-16. In reaching its holding, the Fifth Circuit necessarily rejected Texas' argument that *Pilot Life*'s preemption analysis was not applicable to the IRO process. Texas specifically objected to the Fifth Circuit's extension of *Pilot Life* in its petition for rehearing, but the panel declined to rehear the matter. The issue is now squarely before this Court.

Contrary to the position taken in Respondent's Brief in Opposition (Aetna Brief),[1] the circuits are divided on the proper application of §502(a) to "saved" state-insurance-law remedies. Aetna contends that because *Franklin H. Williams Insurance Trust v. Travelers Insurance Co.*, 50 F.3d 144 (2nd Cir. 1995) ("*Williams Trust*"), and *PAS v. Travelers Insurance Co.*, 7 F.3d 349 (3rd Cir. 1993), were removal cases, the question presented here was not decided.

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[1] Respondents will be referred to collectively as Aetna.

This analysis is wrong. When §502(a) is alleged to be a basis for preemption, it is considered an assertion of complete preemption justifying removal. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987).[2] Neither of these cases held, as Aetna suggests, that conflicts preemption should be resolved by a state court because there was no complete preemption. Rather, these cases explicitly hold that state-insurance-law remedies can be saved from preemption. *Williams Trust*, 50 F.3d at 151 (district court erred in holding §502(a) preempts New York insurance law); *PAS*, 7 F.3d at 356 ("a necessary requirement for conflict preemption is missing here").

The Fifth Circuit, on the other hand, interpreted *Pilot Life* to compel preemption of state-insurance-law remedies under §502(a). This holding is in direct conflict with the Second and Third Circuits' view of the savings clause. In fact, the Fifth Circuit specifically noted that its decision conflicted with *Williams Trust*. Pet. App. at A-15, A-25 n.59. The Second Circuit relied on the plain meaning of the savings clause to hold §502(a) does not preempt a state-insurance-law remedy. *Williams Trust*, 50 F.3d at 151. The Fifth Circuit, cognizant of that holding, ruled precisely the opposite. Pet. App. at A-15. Thus, Aetna's argument that the case is not ripe for adjudication because the Fifth Circuit did not consider the question presented is belied by the Fifth Circuit's opinion.

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[2] *See McClelland v. Gronwaldt*, 155 F.3d 507, 517 (5th Cir. 1998).

Aetna also mistakes the conflict between the Fifth and Seventh Circuits. The Seventh Circuit in *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000), held, in accordance with *Ward*, that state-insurance-law remedies can be enforced in a §502(a) proceeding. This precise reasoning was urged by both Texas and the U.S. Department of Labor ("DOL") in the Fifth Circuit. Moreover, though Aetna disputes the existence of a conflict between the Fifth and Seventh Circuits, at least four Seventh Circuits judges disagree. Judge Posner, joined by Judges Coffey, Easterbrook, and Wood, dissented from the Seventh Circuit's denial of rehearing en banc, stating that *Moran* "creates a square conflict" with the Fifth Circuit. *Id.* at 973 (Posner, J., dissenting from denial of rehearing en banc).

Aetna argues that in *Moran* the Seventh Circuit concluded that Illinois' statute "could not be properly characterized as an alternate or supplemental enforcement mechanism." Aetna Brief at 10-11. Aetna then claims that because Texas' statute is properly characterized as an alternate enforcement mechanism, there is no conflict. *Id.* That is sophistry. As Judge Posner observed, in regard to the *Pilot Life* arguments before this Court, the Texas and Illinois laws are "materially identical." *Moran*, 230 F.3d at 973.[3] The different results do not stem from substantive distinctions in the two states' independent review provisions, but from a difference in the circuits' reasoning. The Seventh Circuit did not characterize the Illinois statute

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[3] In regard to "relates to" analysis, there are relevant differences. *See* Petition for Writ of Certiorari (Petition) notes 10 and 18.

as an alternate enforcement mechanism because it was "not tantamount to the relief offered under sec. 502(a)(1)(B)." 230 F.3d at 971. The Fifth Circuit characterized the IRO process as an alternate remedy because it thought it provided "the identical relief offered under §[502](a)(1)(B)." Pet. App. at A-16-17. This is conflict.

Curiously, Aetna appears to concede that if the IRO process is considered an insurance law incorporated into an ERISA plan, then it would be saved from preemption under this Court's analysis in *Ward*. Aetna Brief at 14. Although Aetna disagrees with this characterization of Texas' independent review law, this was precisely the interpretation given the "materially identical" Illinois independent review provisions at issue in *Moran*. 230 F.3d at 969-70. The Fifth Circuit likewise characterized the IRO process as creating a "procedural right of the insured" (Pet. App. at A-14), but then held that this procedural right could not be enforced. By contrast, the Seventh Circuit held that such a state-created procedural right could be enforced. That is the "square conflict" referred to by Judge Posner—a conflict that is directly before this Court.

Further decisions by other circuit courts of appeal are not needed to illuminate the legal issues presented. The Fifth and Seventh Circuits have diametrically opposed views of the savings clause. The Seventh Circuit allows independent review laws to be enforced; the Fifth Circuit does not. The Second and Third Circuits allow a state-insurance-law remedy to be enforced; the Fifth Circuit does not. Further circuit decisions will necessarily devolve into

one of these two camps. Only this Court's guidance can resolve this issue.

Moreover, while Aetna suggests that "percolation" might resolve the split between the Fifth and Seventh Circuits by inspiring the Seventh Circuit to reconsider its position, the denial of rehearing en banc in *Moran* suggests otherwise. If the Seventh Circuit refused to rehear *Moran* en banc over the vehement protests of Judges Posner, Coffey, Easterbrook, and Wood—who expressly highlighted the "square conflict" with the Fifth Circuit—it is unlikely that percolation will spur some future en banc resolution of the split. Delay serves no useful purpose because the issues have been clearly framed and the well-being of millions of citizens is at stake.

Finally, Aetna claims the question is not ripe for adjudication because Congress is considering legislation that may address Texas' concerns.[4] That Congress is

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[4] Actna also argues in opposition to Texas' Petition that the Court should wait to rule because the DOL has promulgated regulations that may affect the issue of preemption of state external review laws. Those regulations do not, however, provide for independent external review. Rather, the regulations provide only for internal review by a different fiduciary and only require consultation with a health care professional. Pension and Welfare Benefits Administration, 65 Fed. Reg. 70246, 70269 (Nov. 21, 2000) (to be codified at 29 C.F.R. pt. 2560). Texas already provides similar internal review requirements. TEX. INS. CODE art. 21.58A, §6. The IRO process provides for independent, external review. *Id.* art 21.58A, §6A. That is something DOL cannot do by regulations. "DOL says it lacks authority to require independent review." UNITED STATES GENERAL ACCOUNTING OFFICE, REPORT NO. GAO/HEHS-98-154,

considering requiring independent review bespeaks the importance of independent review. But that does not mean Texans should be denied independent review while Congress is considering the issue. Congress may or may not pass such legislation. In addition, the States have an independent duty to promote their citizens' well-being and regulate insurance practices within their borders. The question is not whether Congress may address the issue in the future. Rather, the question is whether the majority of states that have already enacted independent review statutes can enforce these laws. This issue is squarely before this Court, and it warrants expedient resolution.

II. Independent Review Laws Are Laws Regulating Insurance.

Alternatively, Aetna argues the petition should not be granted because the Fifth Circuit erred in finding the IRO process was an insurance law. First, Aetna erroneously claims that Texas' independent review law is not an insurance law, because it can reach self-funded employee benefit plans. Aetna's analysis fails for two reasons. First, a law that relates to a self-funded plan is not necessarily precluded from being an insurance law. Rather, the deemer clause, 29 U.S.C.A. § 1144 (b)(2)(B), prevents a state from applying that insurance law to a self-funded plan. *See FMC Corp. v. Holliday*, 498 U.S. 52, 64-65 (1990); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 735 n.14

EMPLOYER-BASED MANAGED CARE PLANS: ERISA'S EFFECT ON REMEDIES FOR BENEFIT DENIALS AND MEDICAL MALPRACTICE, 14 n.17 (July 1998).

(1985). Second, Texas excludes self-funded ERISA plans from its utilization review law, which is the underpinning of the IRO process.[5] Pet. App. at A-23 n.42. The deemer clause, therefore, is not implicated by this case.

Aetna also argues that the IRO process does not spread risk even though spreading risk is precisely what medical necessity decisions do.[6] Aetna makes much of the fact that its reversals of an attending physician's decision that medical care is necessary purportedly "does not prohibit a member from *receiving* such treatment." Aetna Brief at 15 (emphasis in original). Instead, the member "bear[s] the *financial risk* of covering any desired care that is not medically necessary." *Id.* at 20 (emphasis added).

Aetna would have the Court believe that this case is about members wanting unnecessary medical care and asking Aetna to pay for it. But that is not what Texas' IRO process protects. Instead, the IRO process ensures the provision of medically necessary care by preventing insurers, like Aetna, from erroneously substituting their medical judgment for that of a member's attending physician. Texas' law is about getting medical decisions right so that necessary care is provided.

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[5] Aetna did not challenge that law below, or Texas' long-standing interpretation and application of the law.

[6] The Fifth Circuit questioned whether the IRO process spreads risk, but decided it did not need to address that factor to determine the IRO process was a law regulating insurance. Pet. App. at A-15.

If Aetna incorrectly determines medical necessity and members are forced to pay for care out of their own pockets, then the risk assumed for providing all medically necessary care is transferred back to members.[7] The purpose of Texas' IRO process is to ensure that medically necessary care is provided—and, only medically necessary care. As a result, risk is spread appropriately not just for an individual member, which makes the IRO process integral to the insurer/insured relationship,[8] but for all of Aetna's members. This risk-spreading between an insured and all of its insureds is exactly what insurance is designed to do.

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[7] If a member cannot assume that risk, then necessary medical care is not received. When Aetna or any other MCO exercises medical judgment to determine what care is or is not necessary, it not only performs a traditional insurance payment function, but crosses over into the field of health care. This implicates the states' traditional role of regulating the provision of health care. That is why this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000), is relevant to the analysis of whether Texas' IRO provisions "relate to" ERISA plans. Because of Congress's synonymous use of "relates to" in FEHBA, if Congress did not intend to preempt state health care regulation in ERISA, there is no reason to ascribe a contrary intent with respect to FEHBA. Accordingly, the Fifth Circuit erred when it held Texas' IRO process conflicted with FEHBA.

[8] Aetna argues that the IRO process is not integral to the relationship between the insurer and the insured because it does not define the terms of the policy, it only deals with the administration of those terms. This Court has rejected that analysis. *Ward*, 526 U.S. at 375 n.5.

CONCLUSION

For these reasons, and those set forth in Texas' Petition for Writ of Certiorari, the Court should grant the petition and reverse the judgment of the Fifth Circuit.

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CLERK

Nos. 00-665 and 00-1021

In the Supreme Court of the ~~United States~~

JOSÉ MONTEMAYOR, COMMISSIONER, TEXAS DEPARTMENT OF INSURANCE, ET AL., PETITIONERS

v.

CORPORATE HEALTH INSURANCE, INC., ET AL.

RUSH PRUDENTIAL HMO, INC., PETITIONER

v.

DEBRA C. MORAN, ET AL.

ON PETITIONS FOR WRITS OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE FIFTH AND SEVENTH CIRCUITS

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTIONS PRESENTED

1. Whether state laws providing for external independent review of managed care organizations' medical necessity decisions are preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*

2. Whether state laws providing for external independent review of managed care organizations' medical necessity decisions are preempted by the Federal Employees Health Benefits Act of 1959, 5 U.S.C. 8901 *et seq.* (No. 00-665 only.)

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ON PETITIONS FOR WRITS OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE FIFTH AND SEVENTH CIRCUITS

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's invitations to the Solicitor General to express the views of the United States.

STATEMENT

1. a. *Montemayor.* The *Montemayor* case involves a challenge to a 1997 law (Senate Bill 386), enacted by the State of Texas as an amendment to its insurance code, which, among other things, creates an independent review organization (IRO) process for certain decisions by a health maintenance organization (HMO). 00-665 Pet. App. B2-B3, E1-E7. That process provides for binding external review by an independent physician, at the request of an enrollee, Tex. Ins. Code Ann. § 21.58A (West Supp. 2001), of decisions made "by a

health maintenance organization or a utilization review agent that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary or are not appropriate." *Id.* § 20A.12A(a)(1).

b. Shortly after the passage of the law, Corporate Health Insurance, Inc., and a number of other HMOs and insurers brought suit in the United States District Court for the Southern District of Texas against the Texas insurance commissioner and the state attorney general, arguing that the Texas law is preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, and the Federal Employees Health Benefits Act of 1959 (FEHBA), 5 U.S.C. 8901 *et seq.* The district court held that the provisions of the Act that impose liability on HMOs for providing substandard medical care are not preempted by ERISA or FEHBA. 00-665 Pet. App. B51-B52, B80. The court held that certain other provisions of the Act are preempted by ERISA. *Id.* at B72-B75 (anti-indemnity and anti-retaliation provisions preempted). And, in the ruling pertinent to the principal question presented in these petitions, the court held that the Texas law's provisions for independent review of medical necessity decisions are also preempted by ERISA. *Id.* at B67, B70. See also *id.* at B15 (concluding that the Texas provisions for independent review are not saved as insurance regulation because, in the court's view, they were not limited to entities within the insurance industry). The court held that no provisions of the Act are preempted by FEHBA. *Id.* at B77-B80.

c. The Fifth Circuit affirmed in relevant part. The Secretary of Labor appeared as amicus curiae in the court of appeals, arguing, *inter alia*, that the external review provisions are not preempted by ERISA.

As an initial matter, the court of appeals agreed with the district court that the liability provisions of the state law are not preempted, but disagreed with the lower court's conclusion that ERISA preempts the anti-retaliation and anti-

indemnity provisions. 00-665 Pet. App. A7-A11. The court then addressed the validity of the independent review provisions in light of Section 514(a), 29 U.S.C. 1144(a), ERISA's express preemption provision. It concluded that the IRO provisions "relate to" ERISA plans within the meaning of Section 514(a), reasoning that those provisions "include determinations by managed care entities as to coverage, not just negligent decisions by a physician," and thus fall "squarely within the ambit of ERISA's preemptive reach." 00-665 Pet. App. A13.

Applying the factors articulated by this Court in *UNUM Life Insurance Co.* v. *Ward*, 526 U.S. 358 (1999), the court of appeals further determined that the IRO provisions "regulate[] insurance" within the meaning of ERISA's insurance saving clause in Section 514(b)(2)(A) of the Act, 29 U.S.C. 1144(b)(2)(A). 00-665 Pet. App. A13-A15. The court first concluded that the IRO provisions satisfy the commonsense test of insurance regulation because they apply only to entities acting as insurers, and, by mandating a contract term that includes certain procedural requirements, they go to the heart of the relationship between the insured and the insurer. *Id.* at A14-A15. "For the same reasons," the court held, "the provisions satisfy the second and third prongs of the McCarran-Ferguson [Act]" test of what constitutes an insurance regulation, see *UNUM*, 526 U.S. at 373-374, although they "probably do not meet the first factor of reallocating the risk between the insured and insurer." 00-665 Pet. App. A15.[1]

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[1] The court of appeals thus disagreed with the district court's conclusion that the state law failed to meet the third factor, which requires that a law be limited to the insurance industry, because it applied to managed care entities as well as more traditional insurers. 00-665 Pet. App. A14-A15. The court of appeals reasoned that the relevant inquiry is whether the law is limited in its application to entities (including HMOs) acting as insurers. *Id.* at A14. It found the Texas law to be so limited. *Ibid.*

The court's analysis did not stop there, however. Instead, it held that "even if the provisions would otherwise be saved, they may nonetheless be preempted if they conflict with a substantive provision of ERISA." 00-665 Pet. App. A15. Based on its view that *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41 (1987), held that ERISA's judicial enforcement scheme in Section 502(a) of the Act, 29 U.S.C. 1132(a) (1994 & Supp. V 1999), "preempts not only directly conflicting remedial schemes, but also supplemental state law remedies," the court reasoned that "the saving clause does not operate if the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan." 00-665 Pet. App. A15. The court concluded that the "quasi-administrative procedure" in the IRO provisions for reviewing denials of benefits provides "an alternative mechanism" for obtaining the identical relief offered by Section 502(a), and as such conflicts with Section 502(a). *Id.* at A15-A16.

Additionally, the court concluded that the independent review provisions are preempted by FEHBA because they "specifically conflict with the administrative remedy provided by the Office of Personnel Management concerning benefits disputes." 00-665 Pet. App. A17.

d. On petition for rehearing, the panel rejected the State's argument that this Court's intervening decision in *Pegram* v. *Herdrich*, 530 U.S. 211, 237 (2000), which held that mixed medical-eligibility decisions made by an HMO through its physicians are not fiduciary decisions under ERISA, cast doubt on the court's conclusion that the external review provisions are preempted. The court stated that *Pegram* does not lead to the conclusion that "every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment." 00-665 Pet. App. D2-D3.

2. *Rush Prudential.* Section 4-10 of the Illinois Health Maintenance Organization Act, 215 Ill. Comp. Stat. Ann. 125/1-1 *et seq.* (West 1993 & Supp. 2001), requires an HMO to

submit to binding independent review whenever there is a disagreement between a patient's primary care physician and an HMO over whether a course of treatment is medically necessary. 00-1021 Pet. App. 6a. The *Rush Prudential* case arises from such a disagreement.

a. Respondent Debra C. Moran is a beneficiary under a medical benefit plan sponsored by her husband's employer and governed by ERISA. 00-1021 Pet. App. 3a. Respondent Rush Prudential HMO (Rush) provides "medically necessary" benefits under the plan. *Ibid.*

Moran first sought treatment in 1996 from her Rush-affiliated primary care physician, Dr. LaMarre, for pain, numbness, loss of function, and decreased mobility in her right shoulder. 00-1021 Pet. App. 3a. Moran then consulted at her own expense with Dr. Julia Terzis, an out-of-network surgeon. *Id.* at 3a-4a. Dr. Terzis recommended that Moran undergo a surgical microneurological procedure to correct her problem. *Id.* at 4a. Two Rush-affiliated thoracic surgeons confirmed Dr. Terzis's diagnosis, but recommended a standard and less complicated (and less expensive) surgical procedure. *Id.* at 4a, 5a. Moran, however, supported by Dr. LaMarre, unsuccessfully sought approval from Rush for the procedure recommended by Dr. Terzis. *Id.* at 5a.

b. In January 1998, Moran made a written demand on Rush to comply with the Illinois independent review provision. 00-1021 Pet. App. 6a. When Rush did not act on her request, Moran filed a suit in state court to require Rush to submit to binding independent review. *Id.* at 6a-7a. Rush removed the action to federal district court on the ground that the claim was completely preempted by ERISA, but the district court remanded. *Id.* at 6a-7a, 34a. In the meantime, Moran opted to undergo the surgery by Dr. Terzis in February 1998. *Id.* at 6a. She submitted the bill for $94,841.27 to Rush. *Ibid.*

c. On remand, the state court ordered Rush to submit to independent review. 00-1021 Pet. App. 7a, 36a. The inde-

pendent reviewing physician determined that surgery was medically necessary, and he reported that he would have used a procedure similar to that used by Dr. Terzis. *Id.* at 7a-8a. Rush, however, again denied Moran's claim for reimbursement on the ground that Dr. Terzis's surgery was not medically necessary. *Id.* at 8a.

d. Moran then sought a state court order requiring Rush to reimburse her for the surgery. 00-1021 Pet. App. 8a, 36a. Rush again removed the action to district court, and the district court held that the removal now was appropriate. *Id.* at 36a-43a. The court held that Moran's suit to compel reimbursement for surgery was properly characterized as a claim for benefits under Section 502(a)(1)(B) of ERISA, and as such was completely preempted by the federal law. *Id.* at 41a-42a. Moreover, the court concluded that the state-law claim was not saved from preemption as an insurance regulation under Section 514(b)(2)(A) of ERISA, 29 U.S.C. 1144(b)(2)(A), because the Illinois HMO statute's IRO provision did not transfer or spread the policyholder's risk. 00-1021 Pet. App. 42a-43a.

On Rush's motion for summary judgment, the court concluded that Moran's only viable claim was a claim for benefits under the plan itself. 00-1021 Pet. App. 54a. The court concluded, however, that Rush did not abuse its discretion or act arbitrarily in denying Moran's benefit claim. *Id.* at 56a. The court noted that the plan granted Rush "the broadest possible discretion" in making benefit determinations, and also specified the method by which Rush would evaluate medical necessity determinations. *Ibid.* Because Rush used the specified evaluation method and relied on the opinions of three consulting physicians in making its determination, the court granted summary judgment to Rush. *Id.* at 56a-58a.

e. The Seventh Circuit reversed. The court agreed with the district court that Moran's claim was properly characterized as a claim for benefits under Section 502(a)(1)(B) and

therefore was properly removed to federal court. 00-1021 Pet. App. 13a.

Turning to Rush's preemption defense, the court adopted much of the reasoning set forth by the Secretary of Labor in an amicus brief in support of Moran. The court concluded that the state external review law "relates to" ERISA plans because it "has an effect on how benefit determinations are made." 00-1021 Pet. App. 16a. The court then determined, however, that the external review provision is a state law that "regulates insurance" and therefore falls within ERISA's insurance saving clause. *Id.* at 16a-17a. The court found that Section 4-10 satisfies the "common sense" test of insurance regulation because the independent review provision "is directed at the HMO industry as insurers." *Id.* at 17a. The court also stated that the "common sense" test is satisfied because the terms of the independent review provision "are substantive terms of all insurance policies in Illinois by operation of law," *ibid.*, and are therefore "'integral' to the insurer/insured relationship," *id.* at 18a (quoting *UNUM*, 526 U.S. at 374-375). The court reasoned that, because the independent review provision "changes the bargain between insurer and insured" and "is limited to entities within the insurance industry," it "satisfies the second and third *McCarran-Ferguson* factors." *Id.* at 18a (quoting *UNUM*, 526 U.S. at 374); see also *id.* at 16a (citing McCarran-Ferguson Act, 15 U.S.C. 1011 *et seq.*). Citing this Court's decision in *UNUM*, see *id.* at 18a n.3, the court noted that it therefore need not decide whether the Illinois provision transfers or spreads risk—the third McCarran-Ferguson factor. *Ibid.*

The court next examined whether Section 4-10 is preempted as in conflict with Section 502(a) of ERISA, 29 U.S.C. 1132(a) (1994 & Supp. V 1999), under this Court's decision in *Pilot Life Insurance Co.* v. *Dedeaux*, *supra.* 00-1021 Pet. App. 19a. Although the court recognized that the Fifth Circuit reached a contrary conclusion in con-

sidering the "quite similar" provision of Texas Law in *Montemayor*, *ibid.*, the Seventh Circuit concluded that "§ 4-10 of the Illinois HMO Act cannot be characterized as creating an alternative remedy scheme that conflicts with § 502(a)." *Id.* at 21a. Instead, the court concluded that the independent review provisions of the Illinois HMO statute are incorporated into each participant's insurance contract, and accordingly a suit "to enforce the HMO Act's provisions is simply a suit to enforce the terms of the plan—precisely the sort of suit that is contemplated by § 502(a)(1)(B) 'to enforce rights' and 'to recover benefits' under the plan." *Ibid.* Viewed in that light, the court continued, Section 502(a)(1)(B) remains the "sole launching ground" for enforcement of the state law provision, which simply "adds to the contract, by operation of law, an additional dispute resolving mechanism." *Id.* at 21a, 22a. Therefore, the court concluded that unlike the state common law doctrine of general applicability held preempted in *Pilot Life*, the independent review provision of the Illinois HMO Act imposes state-mandated insurance contract terms of the kind that were held in *UNUM* to be saved as insurance regulation. *Id.* at 23a.

The court circulated its decision to the full court for consideration of the desirability of rehearing en banc in light of the conflict between its decision and that of the Fifth Circuit in *Montemayor*. 00-1021 Pet. App. 23a n.7. Although the court declined to order rehearing en banc, Judge Posner, joined by three other judges, dissented from the denial of rehearing en banc. *Ibid.* In Judge Posner's view, "[t]he panel's decision creates a square conflict with" the Fifth Circuit's decision. *Id.* at 24a. He argued, *inter alia*, that the Illinois external review provision "establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans." *Id.* at 25a. In his view, imposition of that scheme would improperly transform

the contractual suits envisioned by ERISA in Section 502(a)(1) into suits "for judicial review of the independent physician's decision." *Id.* at 26a.

DISCUSSION

At least thirty-seven states and the District of Columbia have enacted laws that require HMOs to provide some form of independent review of benefit denials. See 00-665 Pet. 27 n.24 (citing statutes). Those state laws vary considerably. The question whether they are preempted in light of ERISA's express preemption provision in Section 514, 29 U.S.C. 1144, and its exclusive provision for civil actions in Section 502(a), 29 U.S.C. 1132(a) (1994 & Supp. V 1999), is an important one. Moreover, the Fifth Circuit's decision in *Montemayor* holding that enforcement of the Texas independent review law is preempted conflicts with the Seventh Circuit's decision in *Rush Prudential* that a substantially similar Illinois law is not preempted and may be enforced.

Nonetheless, further review of the principal question presented by these cases at this time is not warranted. In the last Congress, the Senate and the House of Representatives each passed a bill that would have required, as a matter of federal law, that HMOs provide independent external review. Although no bill on the subject was ultimately enacted into law, new bills have been introduced on the subject in the current Congress, and the President has recently endorsed one of them. Each of the primary bills now under consideration would require, as a matter of federal law, that HMOs provide independent external review, although other aspects of the external review provisions in each of the bills (including the extent to which they would supersede state law) vary. If either of those bills becomes law, it would substantially limit the continuing importance of the issue presented by these cases. At this time, with Congress actively considering the various alternatives, it would be appropriate for this Court to defer to the possibility of a

comprehensive legislative resolution of the important social policy issues bound up in the principal question presented in these cases.

1. a. These cases present the question whether ERISA preempts the application of state statutes providing for independent, external review of decisions made by HMOs to deny medical coverage provided under ERISA plans. As petitioners in No. 00-665 point out, at least 37 States and the District of Columbia have enacted statutory provisions in recent years purporting to entitle their citizens to such review. The provisions vary substantially in a variety of respects. 00-665 Pet. 27 n.24. A review of the cited provisions indicates that most of them generally require the regulated entity to comply with the determination reached by the independent reviewer. A great many individuals obtain their HMO health coverage through ERISA plans. Accordingly, the question whether ERISA preempts state independent review statutes potentially affects the broad enforceability of those statutes, and it therefore is a question of substantial importance to many States and their citizens.

b. As Judge Posner recognized in his dissent from denial of rehearing en banc in *Rush Prudential*, the Seventh Circuit's decision in that case conflicts with the Fifth Circuit's decision in *Montemayor*. 00-1021 Pet. App. 25a.

The scope of the Texas and Illinois laws is in pertinent part identical. As explained by the Fifth Circuit, the Texas law "allow[s] a patient who has been denied coverage [by an HMO] to appeal to an outside organization," and it "requires" that the HMO "'comply' with the independent review organization's determination of medical necessity." 00-665 Pet. App. A13. The Illinois law in *Rush Prudential* "requires HMOs to submit to an independent physician review when there is a disagreement over whether a course of treatment is medically necessary," and if "the independent reviewer determines that the treatment is necessary, the

HMO is required under [the Illinois statute] to cover the treatment." 00-1021 Pet. App. 1a-2a.

Analyzing the two laws under ERISA, both courts of appeals concluded that they "relate to" ERISA plans within the meaning of ERISA's express preemption provision, 29 U.S.C. 1144(a). 00-665 Pet. App. A13 (Texas law is "squarely within the ambit of ERISA's preemptive reach."); 00-1021 Pet. App. 16a (Illinois law "squarely falls within ERISA's preemption clause."). Both courts of appeals also concluded that the state independent review laws "regulate[] insurance" and therefore fall within the scope of ERISA's insurance saving clause, 29 U.S.C. 1144(b)(2)(A). See 00-665 Pet. App. A15 (Texas law "meet[s] the common sense test of the saving clause" and "satisf[ies] the second and third prongs of the McCarran-Ferguson test."); 00-1021 Pet. App. 17a-18a (Illinois law "'regulates insurance' under a common sense understanding" and "satisfies the second and third *McCarran-Ferguson* factors."). At that point, however, the two courts parted company.

The Fifth Circuit in *Montemayor* held that, although the Texas law falls within the insurance saving clause, it nonetheless is preempted because it conflicts with Section 502(a) of ERISA, 29 U.S.C. 1132(a) (1994 & Supp. V 1999). The court stated that the Texas law does not "create a cause of action for the denial of benefits." 00-665 Pet. App. A15. But the court held that it does "create[] an alternative mechanism through which plan members may seek benefits due them under the terms of the plan." *Ibid.* In the Fifth Circuit's view, this Court's decision in *Pilot Life* established that "the saving clause does not operate if the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan." *Ibid.* On that basis, the court concluded that "the independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the saving clause." *Id.* at A16. See also *id.* at D6 (Texas law is "plainly a state regime for reviewing benefit decisions and

not a system for implementing a mandated term of insurance regulating a minimal standard of care.").

The Seventh Circuit, by contrast, held that the Illinois provision "cannot be characterized as creating an alternative remedy scheme that conflicts with § 502(a)." 00-1021 Pet. App. 21a. The court concluded that "[r]ather than providing an alternative remedy for Ms. Moran to recover benefits, [the Illinois law] simply establishes an additional internal mechanism for making decisions about medical necessity and identifies who will make that decision in those instances when the HMO and the patient's primary care physician cannot agree on the medical necessity of a course of treatment." *Id.* at 21a-22a. Therefore, "a suit by [Moran] to enforce the [statute's] provisions is simply a suit to enforce the terms of the plan—precisely the sort of suit that is contemplated by § 502(a)(1)(B) 'to enforce rights' and 'to recover benefits' under the plan." *Id.* at 21a.[2] Accordingly, while the Fifth Circuit had held the independent review provisions of the Texas statute preempted, the Seventh Circuit held that the Illinois statute is enforceable.[3]

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[2] To be sure, the *Rush Prudential* case involves a claim by a plan beneficiary for reimbursement of medical expenses after they had been incurred, while *Montemayor* involves a pre-enforcement challenge by insurers to a Texas state law that applies only to ex ante claims for the provision of medical services that the HMO has denied and not claims for reimbursement for services already provided outside the HMO. See 00-665 Pet. 4 n.4. But the Seventh Circuit did not rely on the fact that the case before it involved a claim for reimbursement, rather than for the provision of medical care, and the conclusion that the Illinois statute is not preempted as applied to an ex ante claim for medical services would appear to follow *a fortiori* from the Seventh Circuit's conclusion that the Illinois law is not preempted as applied to an ex post claim for reimbursement. Accordingly, it seems clear under the Seventh Circuit's decision that the Illinois statute is enforceable in the circumstances in which the Texas statute was held by the Fifth Circuit to be unenforceable.

[3] Although it comes to the Court in a somewhat different procedural posture, we see no reason that *Rush Prudential* would provide a better

2. Although there is a two-circuit conflict with respect to the preemption under the current ERISA provisions of mandatory independent review provisions, this Court need not—and in our view should not—grant further review in either case. Primarily, that is because Congress is actively considering legislation that would limit the ongoing importance of the question presented because it would, if enacted, substantially affect the scope of independent review of HMO decisions under ERISA plans and the scope of permissible state-law involvement in that subject. Questions regarding independent review of HMO decisions present serious issues of social and medical policy. Those issues should, if possible, be debated and decided in a legislative—not judicial—forum. Because Congress is currently engaged in precisely that debate, this Court should not grant certiorari to consider the question presented at this time.

a. In the 106th Congress, the House of Representatives and the Senate each passed a version of the so-called "patients' bill of rights" legislation. The Senate bill included a new federal mandate that a group health plan generally must "permit a participant or beneficiary * * * access to an independent external review with respect to an adverse coverage determination concerning a particular item or service" if the coverage was denied as not medically necessary and certain other conditions are satisfied. S. 1344, 106th Cong., 1st Sess. § 121(a) (1999) (adding new Section 503(e) to ERISA); see 145 Cong. Rec. S8623 (daily ed. July 15, 1999).

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vehicle than *Montemayor* if this Court were to grant review. Petitioners in *Rush Prudential* intimate that because that case arose in the factual setting of a suit by a participant, it presents a more appropriate case for review than *Montemayor*, which involves a facial challenge to the state law. 00-1021 Pet. 20 & n.12. On the other hand, the Texas scheme at issue in *Montemayor* is embodied in a more detailed statutory scheme, which could aid this Court's review. At bottom, "the issue is one of law" in both cases that does not turn on factual distinctions. 00-1021 Pet. App. 24a (Posner, J., dissenting from the denial of hearing en banc).

State laws that address independent review of HMO decisions would have generally continued to be analyzed for preemption under ERISA's preemption provision and its substantive provisions. The House bill similarly included a federal mandate that a group health plan or health insurance plan must "provide for an external appeals process" of any coverage decision that "involves a medical judgment." H.R. 2990, 106th Cong., 1st Sess. § 1103(a)(1) and (2)(A)(ii) (1999); see 145 Cong. Rec. H9523 (daily ed. Oct. 7, 1999). State independent review laws would have been preempted if they either failed to satisfy ERISA Section 514 or if they "prevent[ed] the application of a requirement of [ERISA]." See H.R. 2990, *supra*, § 1152(a)(1) and (2).

b. This year, two major bills have been introduced in Congress that would again address independent review of HMO decisions. S. 889, 107th Cong., 1st Sess. (2001), introduced by Senators Frist, Breaux, and Jeffords, would provide generally that HMOs and other health carriers "shall provide * * * participants and beneficiaries * * * with access to an independent external review for any denial of a claim for benefits" that satisfies certain conditions. *Id.* § 131(a) (adding new Section 503B(a) to ERISA). The bill specifies the independent review procedure in some detail, and it further specifies that the States "may provide for the designation or selection of qualified external review entities." *Ibid.* (adding new Section 503B(h)(1)(B)). Otherwise, the bill provides that "[n]othing in this [portion of the bill] shall be construed to affect or modify the provisions of section 514 of [ERISA] with respect to group health plans." *Id.* § 151(a)(2). The President has recently stated that he supports S. 889. See White House Office of Communications, Statement by the President, 2001 WL 513452 (May 15, 2001).

S. 283, introduced by Senator McCain and 13 other Senators, provides that an HMO "shall provide * * * participants, beneficiaries, and enrollees * * * with access to an independent external review for any denial of a claim for

benefits" that satisfies certain conditions. S. 283, 107th Cong., 1st Sess. § 104(a) (2001). It also specifies in some detail the procedures that would have to be employed in providing the independent review. S. 283 contains a number of preemption provisions that address the continuing effect of state law, § 152, including a provision that state independent review laws would generally remain applicable so long as they did not "prevent the application" of the federal provisions, § 152(b).

c. The two major bills introduced during the current Congress, like the ones that the Senate and the House of Representatives passed during the last Congress, would each institute a new federal mandate for HMOs to submit to independent external review of decisions based on medical necessity. They would therefore address the subject matter of the Texas and Illinois statutes at issue in *Montemayor* and *Rush Prudential.*

There are, of course, significant differences in the bills, including differences in the scope of independent review, the incidents of that federally mandated review, and the remaining scope permitted for state laws in the area. Since each of the bills is comprehensive legislation, each also contains numerous and varying other provisions addressing HMOs and other subjects. But the bills suggest that with respect to external review, there is a significant consensus that some form of federally mandated external review is desirable. Thus, insofar as the underlying question in this case is whether HMOs in Texas or Illinois must provide binding independent external review of their decisions, legislation actively being considered by Congress at this time would both address that question on a nationwide basis and substantially alter the nature and analysis of whatever preemption issues may remain in this area.

In *Pegram* v. *Herdrich*, 530 U.S. 211 (2000), this Court addressed a comparably far-reaching claim that called into question the incentive systems that HMOs may utilize. The

Court noted that the claim turned on "judgment[s] about socially acceptable medical risk," which "would * * * necessarily turn on facts to which courts would probably not have ready access." *Id.* at 221. The Court noted that "a debatable social judgment [is] not wisely required of courts unless for some reason resort cannot be had to the legislative process," with its "preferable forum for comprehensive investigations and judgments of social value, such as optimum treatment levels and health-care expenditure." *Ibid.* Such resort to the legislative forum is now occurring with respect to the question of how to design a suitable structure of independent review of HMO health-care decisionmaking. Accordingly, it would be appropriate for this Court to defer review of the principal question presented in these cases until Congress has had the chance to produce a legislative resolution of the important social policy issues at stake.

d. Finally, a number of other factors suggest that review of the principal question presented in these cases may be deferred at the present time while Congress considers pending legislative proposals.

First, although 37 States and the District of Columbia have enacted independent review laws, the two cases here are, to our knowledge, the only cases to date in which the issue of ERISA preemption has been litigated. That suggests that resolution of the question of whether and to what extent such laws are preempted is not at this point so urgent from a nationwide perspective that it requires immediate resolution by this Court. Moreover, although the Fifth Circuit has held that ERISA preempts state laws that require HMOs that furnish health care to ERISA plan members to provide for independent review and has specifically invalidated the relevant provisions of Texas law, nothing in the Fifth Circuit's decision or in its interpretation of ERISA bars HMOs from choosing to provide such review, either as provided by state law or according to other standards, in order to attract new members, provide assurance to their

existing members, and perhaps furnish some protection against liability. The Fifth Circuit's decision therefore will not necessarily have the effect of eliminating all forms of independent external review for ERISA participants and beneficiaries, even in Texas or other States in that circuit.

Second, if Congress fails to enact a law addressing the subject of independent review in the near future and if the application of state laws addressing the subject proves to be problematic for the covered entities, the prevalence of state laws in the area will provide an opportunity for the pre-emption issue to be litigated afresh, and this Court therefore would likely have an opportunity to address the conflict in the circuits in the future. On the other hand, if Congress does enact independent review legislation, the nature of the preemption questions raised by state laws on the subject is likely to change dramatically.[4]

Third, the Fifth Circuit in *Montemayor* addressed the State's claim that this Court's decision in *Pegram*—which held that mixed medical-eligibility decisions made by HMO physicians are not fiduciary decisions under ERISA—"cast doubt" on the court's conclusion that the Texas independent review provision is preempted. 00-665 Pet. App. D2. The court stated that it did "not read *Pegram* to entail that every

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[4] If review were granted, the Court might also find it necessary to address questions concerning the relationship between the ERISA insurance saving clause, 29 U.S.C. 1144(b)(2)(A), and the scope of pre-emption required by ERISA's exclusive remedy provision, 29 U.S.C. 1132(a) (1994 & Supp. V 1999). See *Pilot Life Ins. Co.* v. *Dedeaux*, *supra*; *UNUM Life Ins. Co.* v. *Ward*, 526 U.S. 358, 376 n.7 (1999). That issue may have far-reaching consequences, since it may affect the enforceability of many state insurance regulations (including perhaps even those that provide for liability for insurers) insofar as they apply to insured ERISA plans. Those far-reaching implications suggest that this Court ought not address that issue in a case in which the crucial issue—the availability of independent review to those covered by HMOs—may be resolved on wholly different grounds by Congress.

conceivable state law survives preemption so long as it is based on a mixed question of eligibility and treatment." *Id.* at D2-D3. The Seventh Circuit in *Rush Prudential* did not discuss any analogous argument, perhaps because *Pegram* was decided after the case was briefed. Nonetheless, the *Pegram* argument rejected by the Fifth Circuit would likely be advanced in this Court if further review were granted in either of these cases. See 00-665 Pet. 24-27. The Court would then perhaps find it necessary to address that question, since it goes to the logically antecedent question whether the state law "relates to" ERISA plans, and therefore is within the scope of ERISA's preemption provision at all, regardless of the application of ERISA's insurance saving clause.

In the relatively short time since this Court decided *Pegram*, the federal courts of appeals and state courts have had little opportunity to address the question of what effect, if any, *Pegram*'s discussion of ERISA's fiduciary responsibilities has on ERISA preemption analysis, especially in the context of independent review statutes.[5] The answer to that question could be of very broad significance.[6] If this Court defers review of the principal question presented in

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[5] See *Pappas* v. *Asbel*, 768 A.2d 1089 (Pa. 2001) (*Pegram* requires conclusion that ERISA does not preempt state negligence claim against HMO whose physician refused to permit referral to non-network hospital); *Pryzbowski* v. *U.S. Healthcare*, 245 F.3d 266 (3d Cir. 2001) (relying in part on *Pegram* to conclude that state-law claim against HMO for injuries from delays in approving referrals completely preempted).

[6] If this Court's analysis in *Pegram* leads to the conclusion that ERISA does not preempt state laws concerning medical necessity decisions made by managed care entities in the context of ERISA plans, then that conclusion would apparently apply to self-funded as well as insured plans. It could also have implications for the scope of permissible state-law suits against HMOs arising out of such medical necessity decisions. In those respects, the question concerning the effect, if any, of *Pegram* on ERISA preemption analysis could have very broad implications.

these cases, it will enable the lower federal courts and state courts to explore the connection between *Pegram* and ERISA preemption analysis more thoroughly in the first instance. Insofar as this Court finds it necessary to address that issue in a future case, it would then have the benefit of a fuller development of the issue in the lower federal and state courts.[7]

4. The Fifth Circuit also held that the Texas independent review provisions are preempted "under general conflict principles" insofar as they apply to FEHBA plans. Regulations of the Office of Personnel Management (OPM) establish a detailed administrative procedure for review by OPM of denials of benefits by FEHBA plans, 5 C.F.R. 890.105-890.106, followed by review of OPM's decision under the Administrative Procedure Act, 5 U.S.C. 701 *et seq.*, in federal court. See 5 C.F.R. 890.107. State laws (even those regulating insurance, see 5 U.S.C. 8902(m)(1) (1994 & Supp. V 1999))[8] may neither add to the benefits provided under

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[7] Respondents in *Montemayor* argue that review is not warranted because "[t]he effect of [new claims processing regulations promulgated by the Department of Labor] on the issue of ERISA's preemption of state external review laws has yet to be evaluated by any lower federal court." 00-665 Br. in Opp. 25. The new regulations, however, provide that "[n]othing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section," 29 C.F.R. 2560.503-1(k)(1), and specifically provide that state external review procedures do not "prevent the application of" any federal requirements. See 29 C.F.R. 2560.503-1(k)(2) ("[A] State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing.").

[8] FEHBA's preemption provision states that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent

FEHBA plans nor supplement the federal administrative remedy. The Seventh Circuit did not address any FEHBA preemption question, nor has that question been addressed by any other court of appeals. Petitioners in *Montemayor* present little discussion or analysis of the FEHBA issues in the case. See 00-665 Pet. 27 n.23 (noting simply that "FEHBA preemption * * * entails a 'relates to' analysis"). Accordingly, further review of the Fifth Circuit's determination that the Texas independent review provisions are preempted by FEHBA is not warranted.

CONCLUSION

The petitions for writs of certiorari should be denied.

Respectfully submitted.

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of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law * * * *which relates to health insurance or plans* * * * to the extent that such law or regulation is inconsistent with such contractual provisions." 5 U.S.C. 8902(m)(1) (1994 & Supp. V 1999) (emphasis added).